EZ/EC Health Planning Capacity Survey

Final Report

Submitted to the Assistant Secretary for Planning and Evaluation

**Prepared by the Public Health Foundation
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Report on the EZ/EC Health Improvement Capacity Survey

Executive Summary

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) Department of Health and Human Services (HHS), with the assistance of the Public Health Foundation (PHF), surveyed the directors or acting directors in 141 Empowerment Zones and Enterprise Communities (EZ/ECs) during the summer of 2000. The survey asked about EZ/EC directors' interest in and capacity to engage in health improvement activities (defined as any planned activities to address health issues) as well as their desires for technical assistance in this area.

The mailed survey was conducted from June 2000 through August 2000. An 84% response rate was achieved. The survey findings are organized by five factors of EZ/EC health planning capacity[1] and an additional section focusing on EZ/EC desires for technical assistance.

1. Interest and commitment to health

- Many EZ/EC respondents (88%) reported interest in health issues, and 39% consider health issues among their top priorities.
- Nearly three-quarters of the EZ/ECs are willing to devote some of their own resources (staff and/or financial) for health activities.
  - Almost half (47%) of EZ/ECs said they could see themselves providing staff to work on health planning, and more than a quarter (27%) of the EZ/ECs said they would use both their own staff and their financial resources for health improvement planning in the next year.
- Almost two-thirds (64%) of the EZ/ECs had identified specific health issues as important to them in the past three years.
- EZ/EC leaders reported the most important health issues in their sites were:
  - preventive services (58%)
  - substance abuse treatment (56%)
  - primary care services (52%)
  - barriers for special populations (52%)
- More than half of the EZ/ECs (55%) had targeted special populations for health improvement efforts. Of these EZ/ECs:
  - 71% targeted youth or children
  - 60% targeted racial or ethnic minorities
  - 48% targeted older adults

2. Experience in various health improvement roles

- Half of the responding EZ/ECs had participated in or had planned a health improvement activity during the past year. Of these respondents, 94% reported experience participating in health initiatives led by other groups or government offices, and 84% reported experience in facilitating or mobilizing partnerships to address identified health issues.

[1] Public Health Foundation. 1999. Improving Health in Empowerment Zones and Enterprise Communities: Lessons Learned from the EZ/EC Health Benchmarking Demonstration Project.

- Almost half (48%) of the EZ/ECs reported they had a written health plan for an area that includes the EZ/EC, and, of this group, one-third (33%) wrote the health plan themselves.
- Of EZ/ECs reporting health plans for their areas, more than half (60%) had provided input into these plans.
- About one-third of the sites (38%) had included specific health initiatives in economic development plans.
- One of the main differences between rural and urban EZ/ECs was that urban respondents involved in health improvement activities were almost twice as likely as rural areas to report having experience delivering health improvement programs for the community (e.g., health promotion programs, mental health services, preventive services, primary care services).

3. Availability of expertise and data

- Half of the responding EZ/ECs reported they have access to regularly published information on local health statistics. About three-quarters (78%) of these EZ/ECs stated it was relevant to their information needs.
- As stated earlier, many EZ/ECs have identified specific health issues as important. Of these sites, 39% reported identifying these issues through local health statistics and 82% used community input, including surveys, meetings, or focus groups.
- Many EZ/ECs (79%) reported that local expertise was available to guide the EZ/EC in health efforts.

4. Existence and stability of local administrative structures and site advisory organizations

- Most of the responding EZ/ECs (89%) reported having a general community advisory group. Of these EZ/EC sites, only 29% have a health specific advisory group.
- Having a heath specific advisory group results in a statistically greater likelihood that the EZ/EC has:
  - health integrated into economic development activities
  - involvement in health activities
  - a person or body accountable for health in the EZ/EC
- EZ/EC sites with a health specific advisory group tend to have more experience organizing broad community health improvement planning efforts as well as identifying and assessing priority health issues than those without such an advisory group.
- More than half of the EZ/ECs (52%) had a health agency representative at their last general community advisory group meeting.

5. Established relationships with community officials, business representatives, and health departments

- Most responding EZ/ECs (90%) have business people they can call upon for advice, and 57% have conversed with business people about health issues.
- Of the EZ/ECs that have participated in or planned a health improvement activity in the past year, 59% have some experience facilitating and mobilizing partnerships to address health issues.

- Over two-thirds (69%) of the EZ/ECs are on a first name basis with someone at the local health department. Of those on a first name basis with someone at their local health department, 69% talk with health department personnel about health issues at least quarterly.

6. Technical assistance

- More than three-quarters (76%) of the responding EZ/ECs said they would use technical assistance, if offered, for the participation of residents and community groups in EZ/EC-led activities.
- EZ/ECs most frequently that they would use technical assistance for:
  - participation of residents and community groups in EZ/EC-led activities (76%)
  - support staff for meeting planning, minutes, and mailings (71%)
  - a planning body or person accountable for health in the EZ/EC (71%)
  - guiding health planning efforts with community input (70%)
  - local expertise to guide the EZ/EC health efforts (70%)
- More than half (57%) of the EZ/ECs said they would use technical assistance working with their mayors or other elected officials to bring about health improvements in their communities.
- More than half (57%) of the EZ/ECs said they would like technical assistance from their local health departments. Slightly less than half (45%) said they would like help from HHS Federal or regional offices. About one-third (32%) of EZ/ECs would use assistance from a state health department.

Recommendations

The responses to the health capacity survey show that many EZ/ECs already have the basic level of readiness to undertake and sustain successful health improvement efforts and to benefit from technical assistance. Maximizing the capacity of the EZ/ECs to engage in health planning and health improvement activities will facilitate meeting the nation's goal to eliminate health disparities.

The following recommendations to HHS address the key objectives of this survey—to assess EZ/EC health planning capacity and technical assistance needs. These recommendations are based on the survey findings and are consistent with the lessons learned from the EZ/EC Health Benchmarking Demonstration Project. They reflect the professional judgement of the PHF project team and suggest ways to build on existing EZ/EC health capacities reported by the 119 respondents.

- Encourage EZ/EC leaders to explicitly make health issues one of their top priorities. EZ/EC leaders who reported health issues as among their top priorities also reported the most experience in health planning activities.
- Promote the formation of health specific advisory structures in EZ/EC sites. It is apparent from the survey that organizational structures such as health advisory groups are linked to accountability for health, involvement in health activities, and integration of health initiatives in economic development plans. An important focus of future efforts could be follow-up with EZ/ECs that have health specific advisory groups to probe why they work, how they are structured, and how they should function.

- Encourage EZ/EC leaders to form links with local health departments, and vice versa, to work on health improvement efforts. There already are mechanisms and activities in place that the Federal government could use to promote these linkages such as EZ/EC workshops. Also, EZ/EC leaders could be encouraged to contact their local health departments and invite health agency representatives (the least cited participants in EZ/EC advisory group meetings) to attend meetings and planning sessions. To encourage local health departments to reach out to EZ/ECs, the National Association of County and City Health Officials (NACCHO) and other public health agency associations could promote EZ/EC health improvement opportunities to their members. Information that EZ/EC survey respondents stated specifically that they would like assistance from local health departments may further encourage those health departments to contact EZ/ECs to offer assistance. In addition, inform public health agencies about EZ/EC strengths that can fill gaps in community-wide health improvement capacity, such as EZ/ECs inroads with Mayors and businesses—this knowledge may motivate them to contact EZ/EC directors, particularly if they feel welcome to do so.
- Base technical assistance to a majority of EZ/ECs on the formation of and participation in dynamic partnerships to address specific health issues in which EZ/ECs already have interest and experience. In addition, provide targeted assistance to the minority of EZ/ECs that report that they see themselves organizing broad health improvement planning efforts in the next three years.
- Adopt a two-tiered technical assistance strategy to further develop and reinforce EZ/EC strengths and to develop weak areas. Respondents indicated desires for assistance at both ends of the capacity continuum (i.e., areas for which EZ/ECs reported the strongest and weakest capacity).
    - As a first step, identify specific health improvement activities that match current EZ/EC health planning capacities and build upon self-assessed strengths, such as a history of collaboration with their mayors and a knowledge of their own communities.
    - As a longer-term strategy, build EZ/EC health planning capacities in areas where they have identified their own weaknesses, such as participation of residents in EZ/EC activities, availability of support staff, and accountability for health in the EZ/EC.

Introduction

Recognizing that EZ/ECs represent some of the nation's most economically disadvantaged and ethnically diverse urban and rural areas, ASPE proposed a survey that would measure the level of interest, commitment, and priority assigned to health projects in these areas. The results of the survey are expected to assist HHS in helping EZ/EC localities devise health planning approaches that reflect both community needs and appropriate public health standards.

The EZ/EC survey project is designed to build upon ASPE's ongoing efforts with EZ/ECs (described below). Community capacity to embark on health planning is an important factor that influences successful health improvement efforts, as well as the type of technical assistance needed by EZ/ECs to improve the health of their residents. Profiling the readiness of communities, and matching capacity levels to the most appropriate type of technical assistance was the next logical step in developing a strategy for improving health in these EZ/ECs.

The Health Planning Capacity Survey was designed to: (1) identify and assess characteristics associated with EZ/EC capacity to conduct a health improvement planning process, particularly addressing health disparities; (2) characterize EZ/EC experiences with health-related activities besides EZ/EC-initiated health improvement planning; and (3) identify areas relevant to health improvement planning in which EZ/ECs desire assistance.

Background

EZ/EC Initiative

In December 1994 the Federal government launched an initiative to spark an entrepreneurial effort and private investment in communities experiencing economic hardship and high unemployment. It designated 105 poor and underdeveloped urban and rural communities as Empowerment Zones (EZs) and Enterprise Communities (ECs). The Community Empowerment Board, headed by Vice-President Al Gore, directs the EZ/EC Initiative. The EZ/EC initiative is a comprehensive approach to community development through performance oriented block grants.[2] Currently, there are 141 areas designated as an EZ or an EC.

Demonstration Project

This Health Planning Capacity Survey builds upon the findings of an EZ/EC demonstration project in Denver, Colorado; New Haven, Connecticut; and Wilmington, Delaware. These were designated as ECs in 1994. Because of their significant progress in achieving initial economic "benchmarks" (written quantifiable goals), ASPE selected the three sites to participate in the 1998 EZ/EC Health Benchmarking Demonstration Project. PHF, with ASPE's financial support, provided technical and facilitation assistance to the three demonstration sites.

[2] Adapted from – http://www.hud.gov/cpd/ezec/ezecinit.html. September 26, 2000

After an 18-month project period, PHF presented its findings in a report[3] consisting of 12 lessons learned with examples from the three EZ/EC demonstration sites and tips from directors, site participants, and project staff based on EZ/EC experiences. In addition, PHF concluded that five capacity factors most influence whether or not an EZ/EC will succeed on a health improvement journey. These five factors are: (1) interest in and commitment to health; (2) experience in various health improvement roles; (3) availability of expertise and data; (4) existence and stability of local administrative structures and site advisory organizations; and (5) established relationships with community officials, business representatives, and health department staff.

The demonstration project sites' experiences reinforced the idea that EZ/ECs that show a basic level of readiness to undertake health improvement efforts are better able to benefit from technical assistance and to sustain successful health improvement efforts.

The demonstration project pointed to the importance of developing ways to measure EZ/EC health improvement readiness, including interest, ability, and other capacity factors. The EZ/EC health planning capacity survey was developed to measure these EZ/EC health improvement capacities and determine areas where technical assistance could be most useful for advancing health improvement initiatives.

Future Uses of Data

This report profiles EZ/EC readiness and interest in health planning and health improvement. The results of the survey can assist HHS and other Federal agencies in future efforts to:

- Mobilize existing resources to support EZ/EC health status improvement efforts;
- Improve the capacity of EZ/ECs to develop health benchmarks, including realistic, community-specific, health improvement programs and measures;
- Support the EZ/EC roles in health improvement efforts, particularly linked to health disparities and economic development issues; and
- Devise realistic health planning programs that reflect both community needs and appropriate public health standards.

[3] Public Health Foundation. 1999. Improving Health in Empowerment Zones and Enterprise Communities: Lessons Learned from the EZ/EC Health Benchmarking Demonstration Project.

Summary of Data

Methodology

Written surveys were mailed to 141 EZ/EC directors or acting directors. The following table outlines the timeline for survey distribution:

Activity	Timeline
Office of Management and Budget clearance	6/7/2000
Advanced notice letter mailed	6/26/2000
Cover letter and survey mailed	7/3/2000
Reminder postcards mailed	7/11/2000
Follow-up calls	Week of 7/24/2000
Second round of follow-up calls placed from HHS regional offices	Week of 8/2/2000
Second mailing of survey via Federal Express	8/10/2000
Response deadline	8/24/2000

The survey received a high response rate with 84% (119) returned in time for inclusion in this analysis. The number of rural versus urban respondents was virtually equal—85% of all rural EZ/ECs responded as compared to 84% of urban EZ/ECs.

There are several limitations to the survey that should be acknowledged. The actual activities that respondents described were not independently verified. Questions asked drew on subjective self-assessments, e.g., whether or not a community had "strong," "some," or "weak" capacity in health improvement planning. The survey was sponsored by a Federal agency, ASPE, and although a cover letter specifically stated that responses would not affect individual EZ/EC funding, the respondents may have thought otherwise and answered in a way they perceived to be desirable.

Data Summary

Who the Respondents Are

Respondents answered from all ten HHS designated regions (see Appendix 2, Figure 3 for a map of HHS regions). Almost a quarter (24%) of the respondents are from Region 4, in the southeastern United States. (Region 4 also has the most EZ/EC sites.) Regions 3 and 7 had a 100% response rate (see Appendix 2, Figure 2). An analysis of the urban and rural vs. respondents and non-respondents to the survey produced a chi-square of .13 with a p-value of .7166, showing no significant difference between respondents from rural and urban areas (see Appendix 2, Figure 1 for a breakdown of rural vs. urban EZ/ECs).

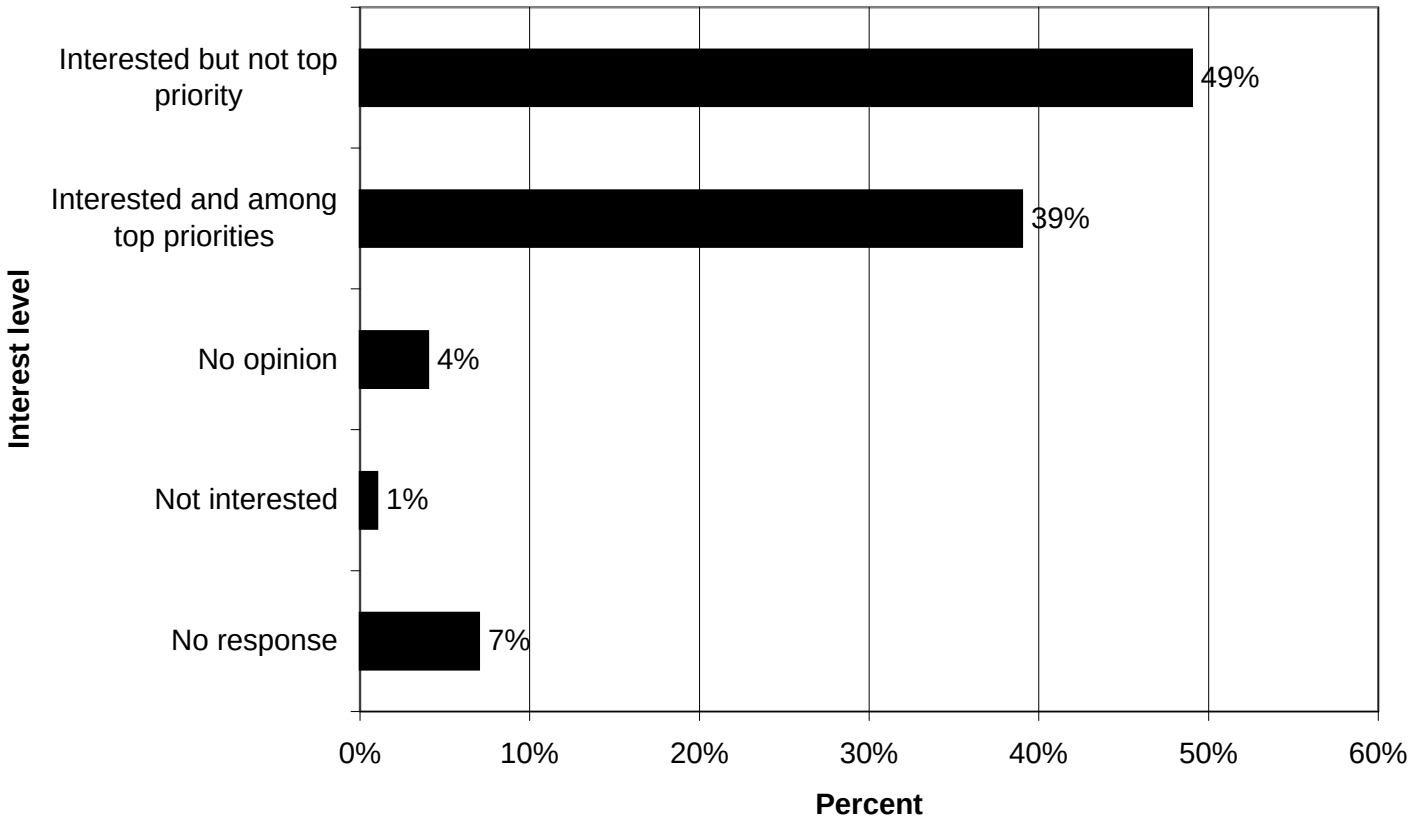
Presentation of Findings

The EZ/EC survey explored five factors of EZ/EC health planning capacity, drawn from PHF's experience working with three EZ/ECs in a demonstration project. The following data summary is separated by these five factors with an additional section focusing on desired technical assistance.

1. Interest and commitment to health

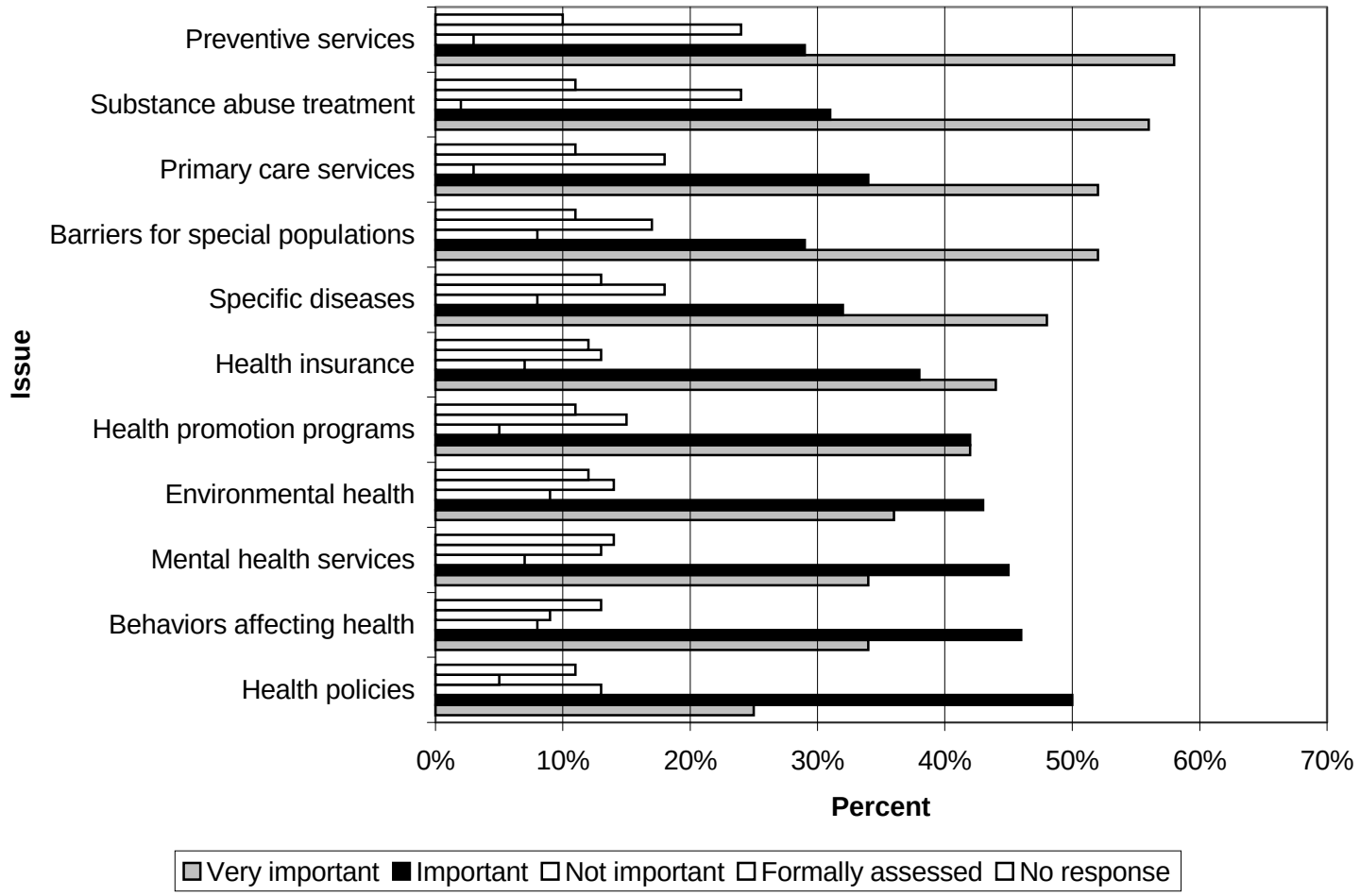
More than 85% of the respondents said that addressing health issues was of interest to them and 39% considered it among their top priorities (see Figure 1).

Figure 1. Interest in addressing health issues in the EZ/EC (N=119)



Almost two-thirds (64%) of the EZ/ECs said they had identified specific health issues as important to them in the past three years. Responding EZ/ECs reported several health issues as very important, including preventive services, substance abuse treatment, primary care services, and barriers for special populations (see Figure 2). Figure 2 also shows the three areas EZ/ECs reported formally assessing - preventive services, primary care services, and substance abuse treatment.

Figure 2. Importance of specific health issues (N=119)[4]



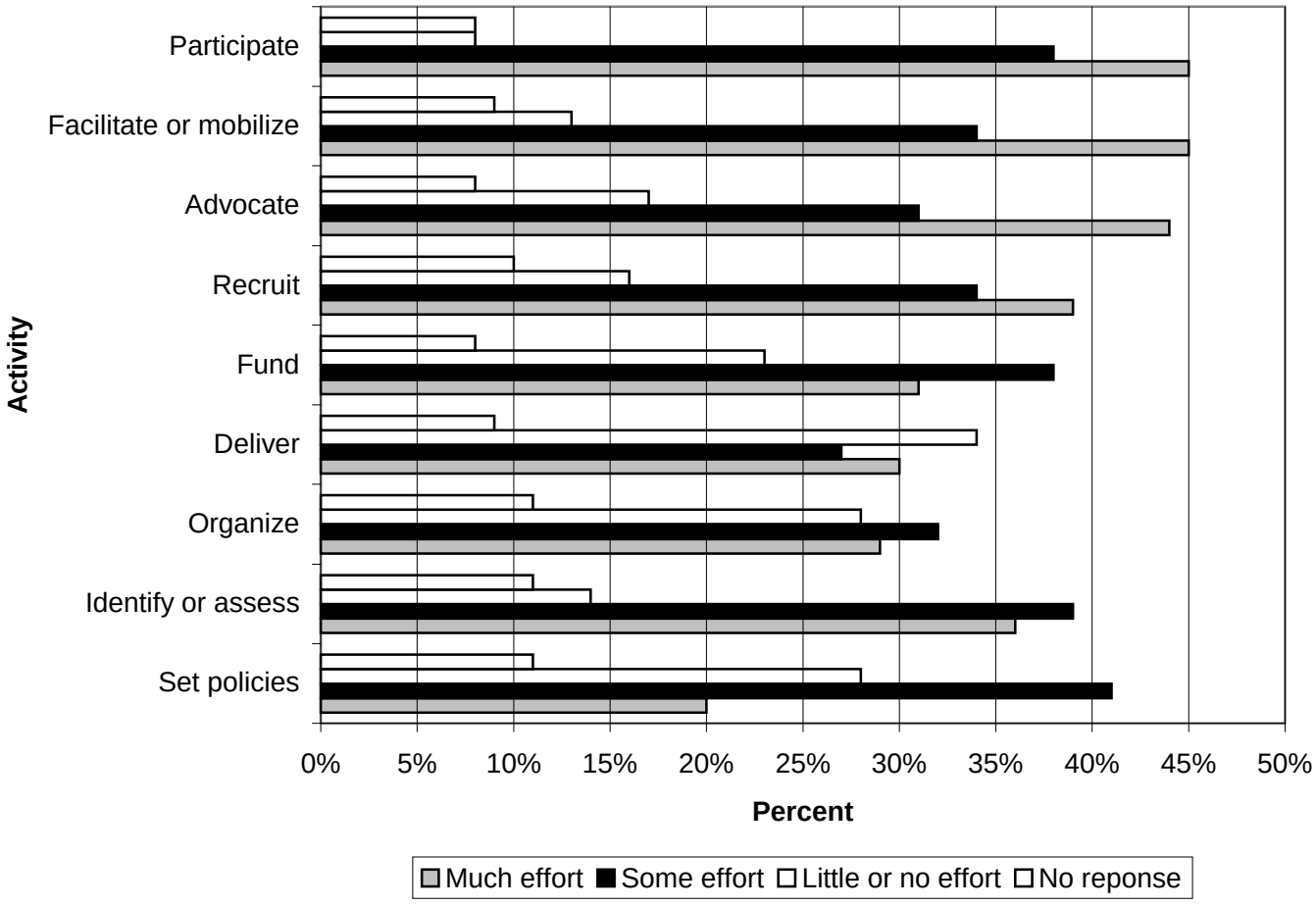
According to Figure 3, EZ/ECs are most likely to invest effort in health improvement activities over the next three years that focus on:

- Participating in health initiatives led by other groups or government offices
- Facilitating or mobilizing partnerships to address identified EZ/EC health issues
- Advocating for health policies, health programs, and services to address EZ/EC needs
- Recruiting EZ/EC residents to participate in health efforts

EZ/ECs that are likely to invest much effort in organizing community health improvement planning efforts are most likely to be interested in health issues and see health issues as a top priority (see Appendix 2, Table 18). Also, not surprising, the EZ/ECs that are likely to invest much effort in organizing community health improvement planning efforts are the EZ/ECs with much experience organizing community health improvement planning efforts (see Appendix 2, Table 20).

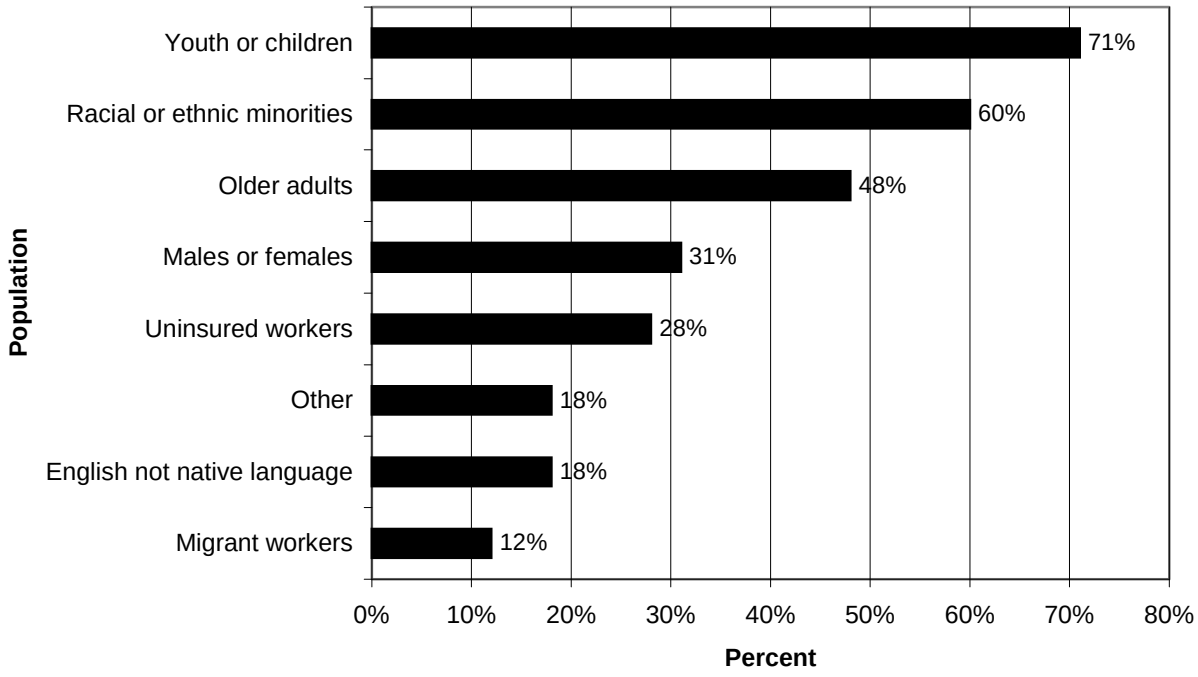
[4] The questionnaire asked EZ/EC directors to indicate the importance of a given issue area and to indicate if it had been formally assessed.

Figure 3. Level of effort EZ/EC is likely to invest in next three years (N=119)



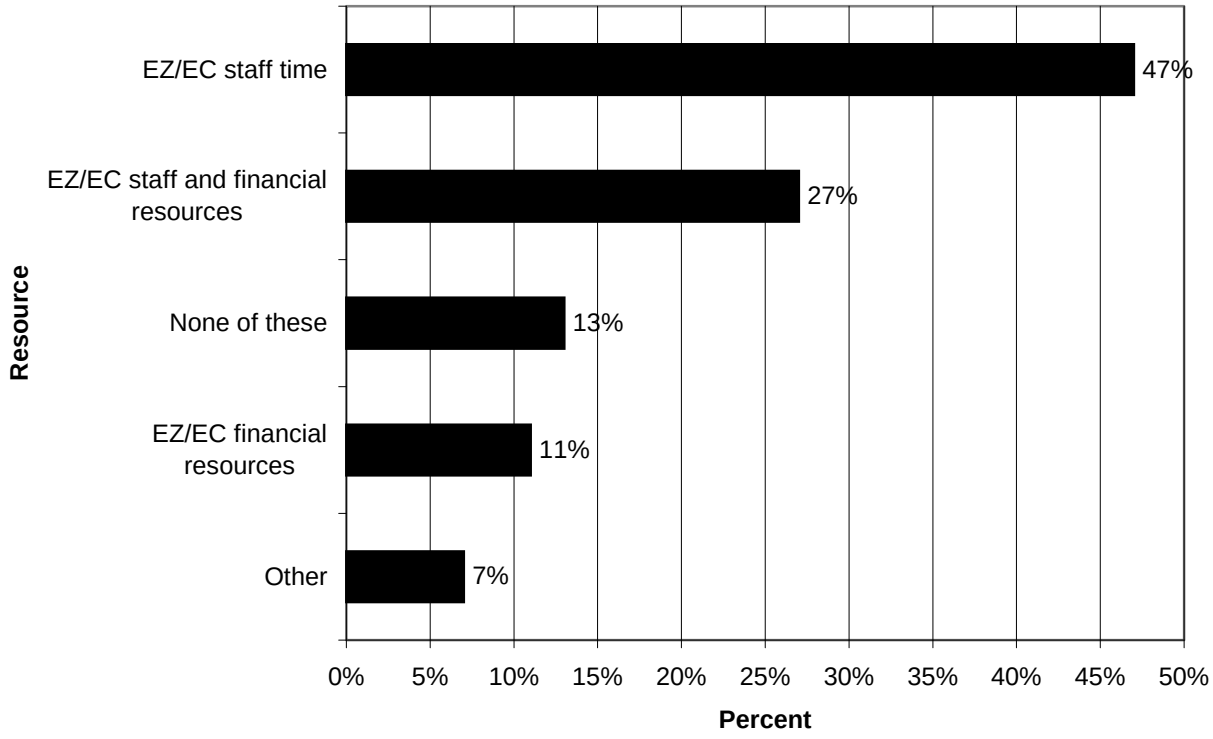
Over half (55%) of the responding EZ/ECs reported they had targeted special populations for health improvement efforts. Of these EZ/ECs, the most commonly targeted special populations included youth (71%), racial and ethnic minorities (60%), and older adults (48%) (see Figure 4).

Figure 4. Special populations targeted for health improvement efforts (N=65)



Many respondents (47%) reported that they could see themselves making staff time available in the next year to improve health in the EZ/EC. In addition, 38% said they could see themselves making financial resources available for health initiatives or health improvement in the coming year (see Figure 5). An interesting note – EZ/EC leaders who reported that the EZ/EC could not make both staff time and financial resources available in the next year to improve health were more likely to be those who reported that addressing health issues interested them but was not a top priority (see Appendix 2, Table 19).

Figure 5. Resources EZ/EC could make available in next year (N=119)[5]

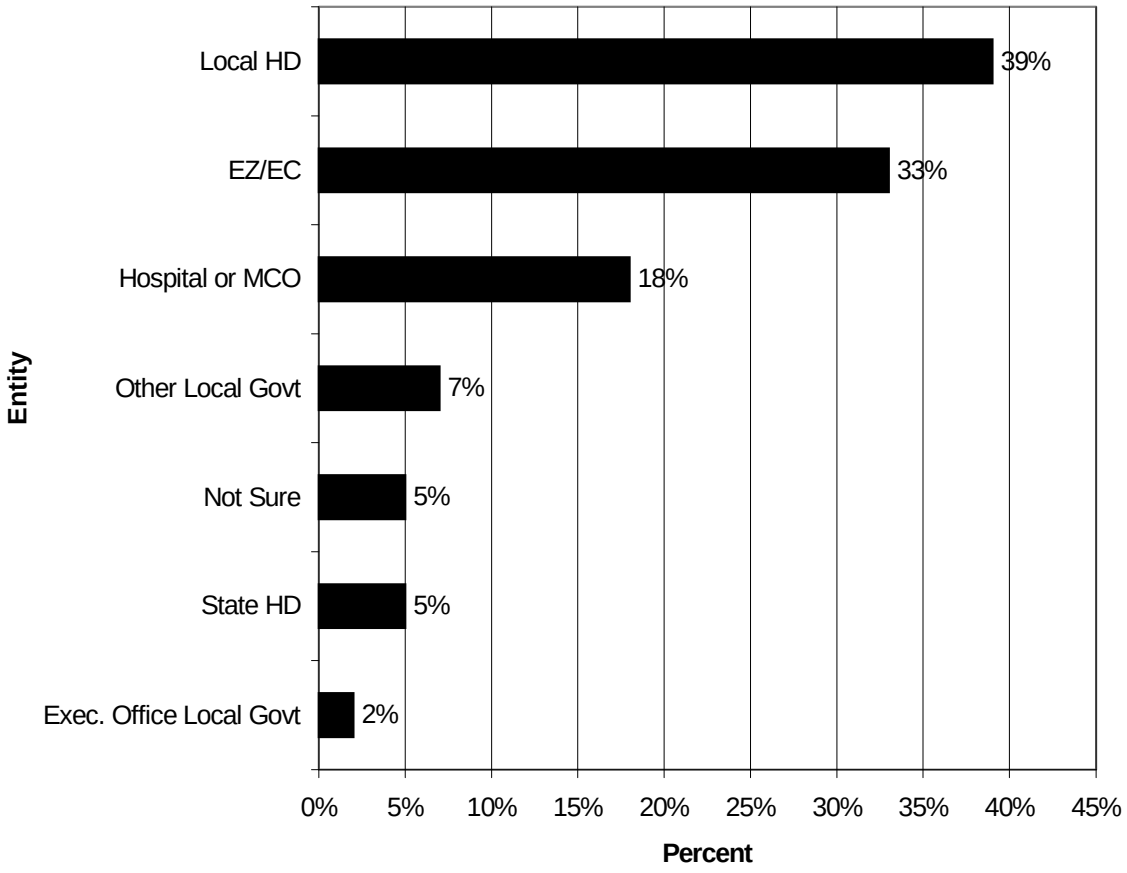


2. Experience in various health improvement roles

The EZ/ECs have considerable experience in various health improvement roles. Almost half (48%) reported that the local area that includes the EZ/EC had a written health plan issued within the past five years. Of those with a written health plan, one-third of the EZ/ECs issued those written health plans, while 39% reported that the local health departments issued written health plans (see Figure 6). Other entities that created health plans for EZ/EC communities included a Latino health institute, a maternal and child health coalition, a local United Way group, a tribal council, a Federal health center, a local community health center, a medical university school of nursing, and a W.K. Kellogg funded health project. Of EZ/ECs reporting written health plans for their areas, three-quarters reported that the health plans target the elimination of racial and health disparities, and more than half of these EZ/ECs (60%) provided input into the health plans.

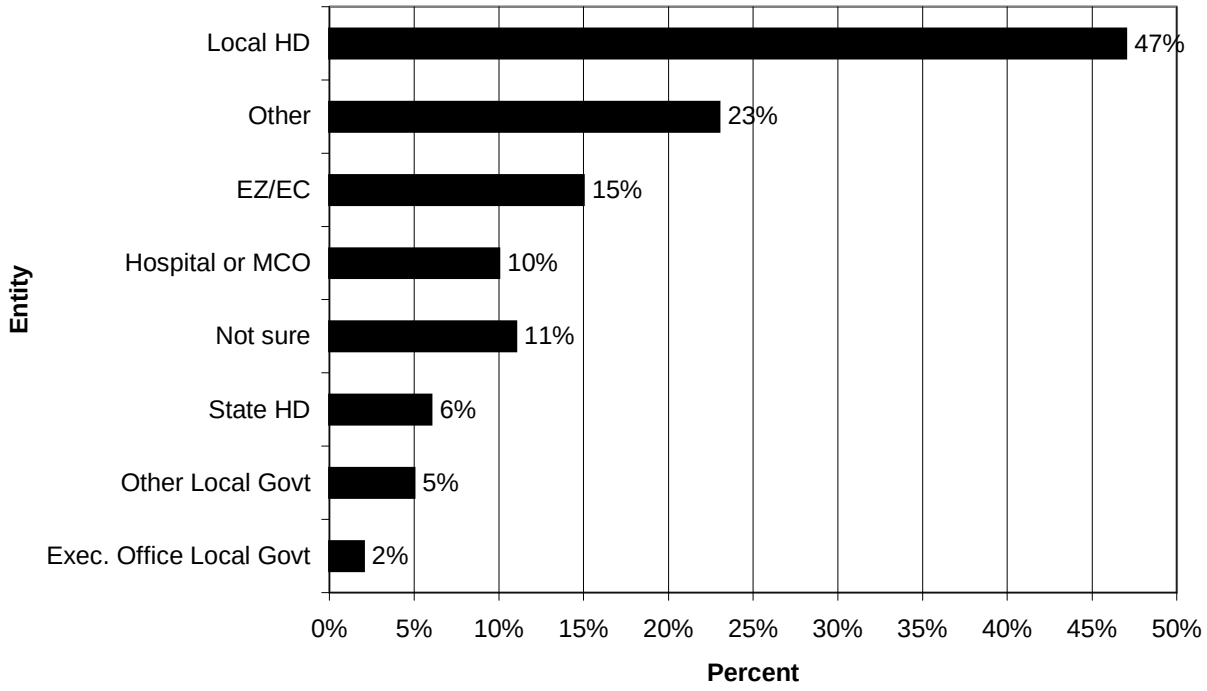
[5] The percentages in this graph add to more than 100% due to rounding error or repondents choosing more than one response.

Figure 6. Organizations that EZ/EC reports issued written health plans for their areas (N=57)



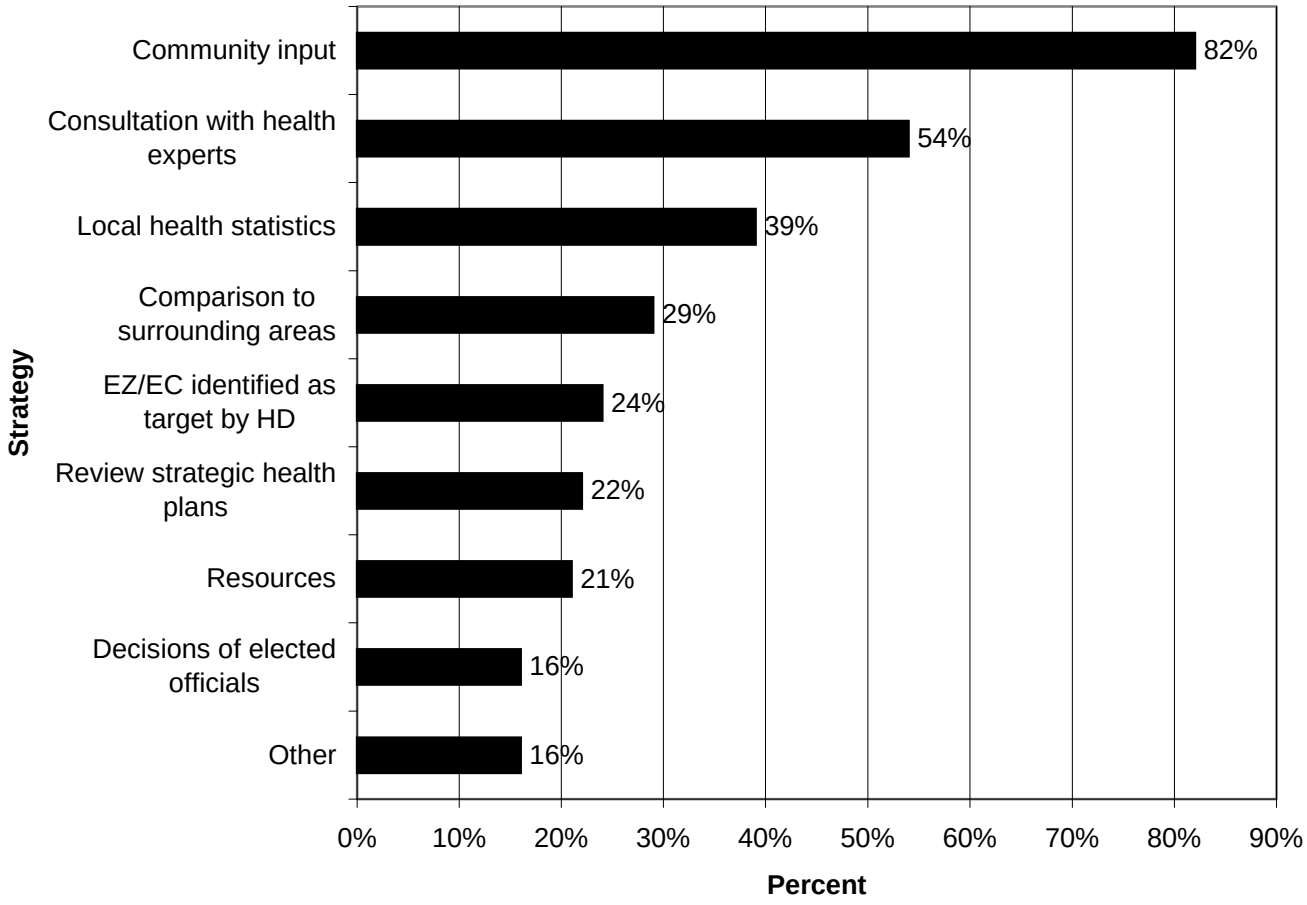
Similar to the finding of the 1998 demonstration project, there was some confusion among EZ/EC survey respondents about who was in charge of local health planning. They did not consistently identify a governmental public health agency as the entity in charge. Approximately half (53%) of the responding EZ/ECs reported state and local health departments as being in charge of health planning and monitoring for the EZ/EC (see Figure 7). A small percentage (15%) of EZ/ECs reported themselves as the entity in charge of health planning and monitoring for the EZ/EC. Outside of the listed choices, many other entities were recognized including: a Latino health institute, rural health advisory council, tribal projects within the EZ/EC, a W.K. Kellogg Foundation funded health project, consortium of health care organizations, tribal areas, community health organizations, health clinics, community health centers, Indian Health Service, and a school of nursing. Even though local health departments were not identified as being in charge of health planning and monitoring by a majority of EZ/ECs, 69% of responding EZ/ECs reported being on a first name basis with someone at their local health department.

Figure 7. Entity in charge of health planning and monitoring for the EZ/EC (N=119)



As stated earlier, almost two-thirds (64%) of the EZ/ECs said they had identified specific health issues as important to them in the past three years. More than 80% of the EZ/ECs that identified specific health issues as important reported that these were identified through community input (see Figure 8).

Figure 8. How EZ/EC identifies specific issues (N=76)



Half of the responding EZ/ECs reported they had participated in or planned a health improvement activity in the past year. Main issues (as reported in an open-ended question) that recent EZ/EC health improvement campaigns and activities addressed included:

(1) Planning/Prevention
- Development of health improvement plan
- Prevention of common diseases
- Elimination of health disparities
- Comprehensive regional health assessment
- Accessibility of healthcare in rural areas
- Helped initiate a Healthy Start consortium
- Workforce development

(2) Age specific programs
- Well child programs
- Teen pregnancy prevention
- Health screening for older persons
- Respite service for primary care givers of the elderly handicapped

(3) Specific diseases or health conditions
- Asthma studies
- HIV/AIDS education
- Substance abuse treatment
- Diabetes and kidney problems
- Lead paint abatement
- Dental care
- Homelessness
- Tuberculosis
- Hypertension
- Nutrition

(4) Services and events
- Healthcare access
- Health fairs
- Healthcare for uninsured workers
- Healthcare provider training and promotional campaigns

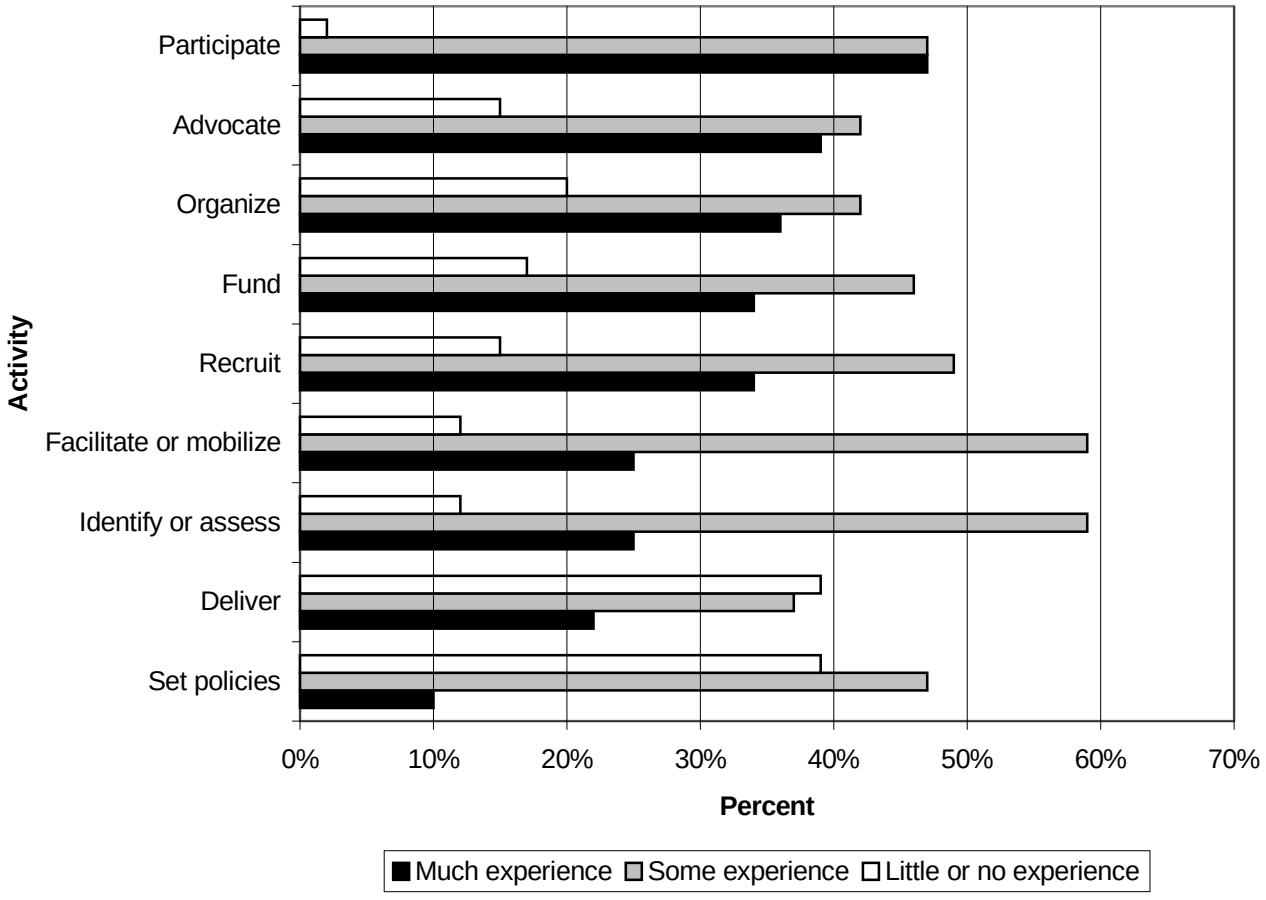
Most of the EZ/ECs that have participated in or planned a health improvement activity in the past year reported experience in a wide variety of these activities (see Figure 9). These EZ/ECs reported "much experience" more often in two areas: 1) participating in health initiatives led by other groups or government offices; and 2) advocating for health policies, health programs and services to address EZ/EC needs. Two activities for which more than half the EZ/ECs claimed "some" experience were in: 1) identifying or assessing EZ/EC needs, and 2) facilitating or mobilizing partnerships to address identified EZ/EC health issues. Experience in organizing community health improvement efforts was directly related to interest in addressing health issues. Those respondents who reported much or some experience in organizing community health improvement planning efforts were most likely to be interested in addressing health issues and considered health issues to be a top priority in the EZ/EC. It is interesting to note that EZ/EC directors who said they had little or no experience organizing community health improvement planning efforts were still likely to report interest in health, even though health was not a top priority (see Appendix 2, Table 17).

About one-third of the EZ/ECs (38%) had included health initiatives in economic development plans. Specific examples include:

- training for home health aides
- provided funding for Healthcare Fair in EC
- provided funding for C.N.A. training
- funded a tele-medicine study
- job training with local hospitals

- recruitment of dentists and doctors
- establishment of health centers
- assist eldercare and assisted living centers
- created Health Career Academy
- about to begin with groundbreaking on rehabilitation hospital for paralysis
- contracted with local nonprofit for medical training
- lead abatement
- HIV/AIDS projects
- healthcare for homeless
- clinics in low-income neighborhood
- provided customized training for surgical technicians
- job training for health-related fields
- improvement of EMS system
- entrepreneurial training for health related businesses
- screening and health prevention programs

Figure 9. Level of experience with health improvement activities (N=59)



However, interest in health issues did not necessarily determine health initiatives being included in economic development plans (see Table 1). Only half of the respondents interested in health issues included them in economic development plans.

Table 1. Cross-tab of interest in addressing health issues and including health initiatives in economic development initiatives

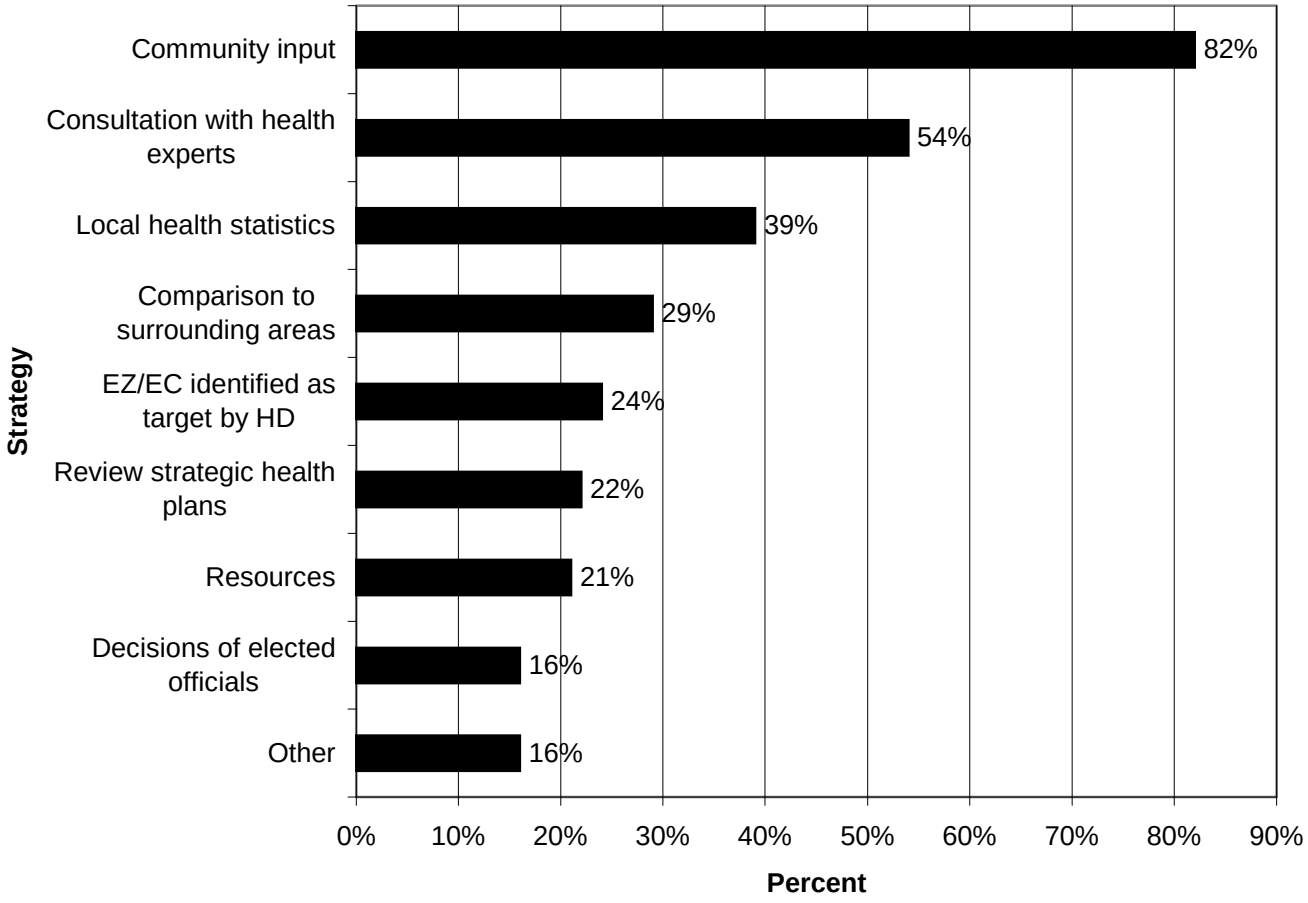
	Included health initiatives in economic development initiatives	
Interest in addressing health issues	**Yes**	**No**
Interested and top priority	20	20
Interested but not top priority	24	31
Not interested	0	1
No opinion	0	5

Urban respondents involved in health improvement activities are almost twice as likely as rural areas to have experience delivering health improvement programs to the community. Urban areas more frequently reported having much experience identifying or assessing EZ/EC health needs, facilitating or mobilizing health partnerships, participating in health initiatives led by others, and recruiting EZ/EC residents to participate in health efforts. Rural areas more frequently reported having some or much experience setting policies within the EZ/EC that support a healthy workforce or community (see Appendix 2, Table 47).

3. Availability of expertise and data

Half of the responding EZ/ECs reported that they have access to regularly published information on local health statistics complied in the last three years. About three-quarters of these EZ/ECs (78%) stated that the reports are relevant to EZ/EC information needs. Those who felt the reports did not meet their needs stated two similar reasons: 1) data at less than the county level are imprecise; and 2) the county profile information is not specific to individual census tracts. Exactly 39% of the EZ/ECs that identified specific health issues as important reported that they used local health statistics to identify these health issues (see Figure 10). Many EZ/ECs (79%) reported capacity for the availability of local expertise to guide the EZ/EC in health efforts.

Figure 10. How EZ/EC identifies specific health issues (N=76)



4. Existence and stability of local administrative structures and site advisory committees

Most of the responding EZ/ECs (89%) have a general community advisory group. Of these EZ/ECs, most reported that this group meets regularly (93%) and they have authority to make decisions that determine EZ/EC activities (78%). Of the EZ/ECs that have a general advisory group, approximately half (52%) reported having a health agency representative at the most recent meeting of this advisory group. However, out of six possible choices health agencies were named least frequently.

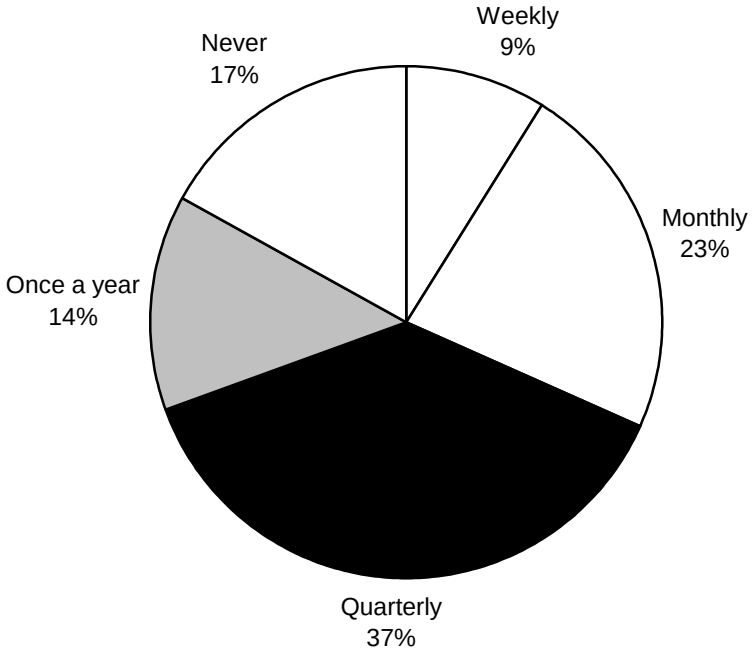
About a quarter (29%) of the EZ/ECs said that they had a health specific advisory group. The presence of the health advisory group was significantly related to the EZ/ECs capacity for planning and health improvement efforts. The health advisory groups were associated with the integration of health initiatives into economic development plans, involvement in health activities, accountability for health in the EZ/EC, and staff familiarity with community issues (see Appendix 2, Tables 12 and 32). EZ/ECs with a health advisory group tend to have more experience with identifying and assessing EZ/EC health needs and organizing broad community health partnerships to

address identified EZ/EC health issues (see Appendix 2, Tables 35 and 36). However, many EZ/ECs without health advisory groups still have "some" or "much" experience in the listed facets of health improvement planning.

5. Established relationships with community officials, business representatives, and health departments

Over two-thirds (69%) of EZ/ECs are on a first name basis with someone at their local health department. Of these EZ/ECs, 69% discuss health issues with this person at least quarterly (see Figure 11). Ninety percent of responding EZ/ECs said that they had business partners whom they can call for advice about EZ/EC issues, and 57% said they have had a conversation about health issues with EZ/EC business people.

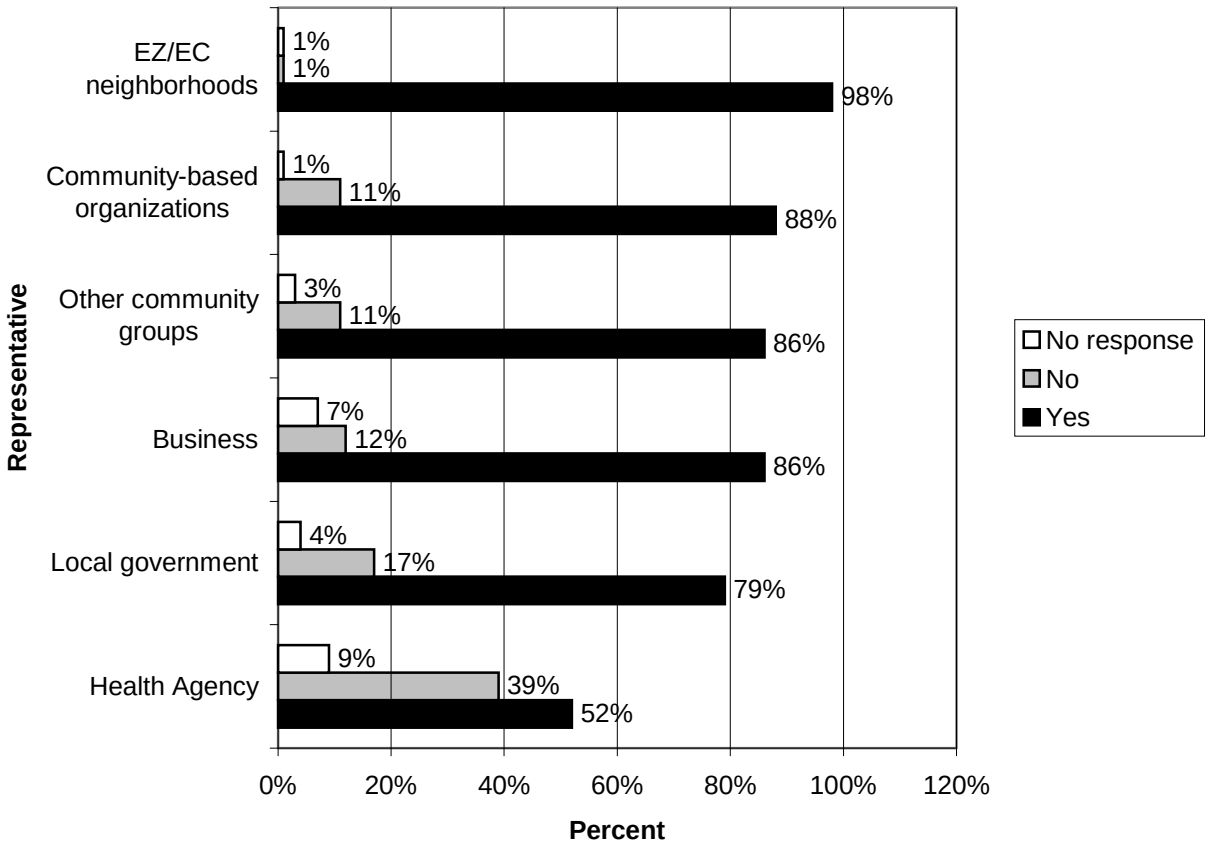
Figure 11. How often health issues are discussed with local health department (N=82)



EZ/ECs have established community relationships with a variety of entities by inviting them to participate in general advisory group meetings. These include EZ/EC neighborhood residents, businesses, health agencies, community-based organizations, local government, and other community groups (see Figure 12). EZ/ECs also rely on community input when identifying specific health issues as important to the EZ/EC. Of the EZ/ECs that have participated in or planned a health improvement activity in the past year (50%), 59% have some experience facilitating and mobilizing partnerships to

address health issues. All of these factors can be built upon to further health improvement planning efforts in EZ/ECs.

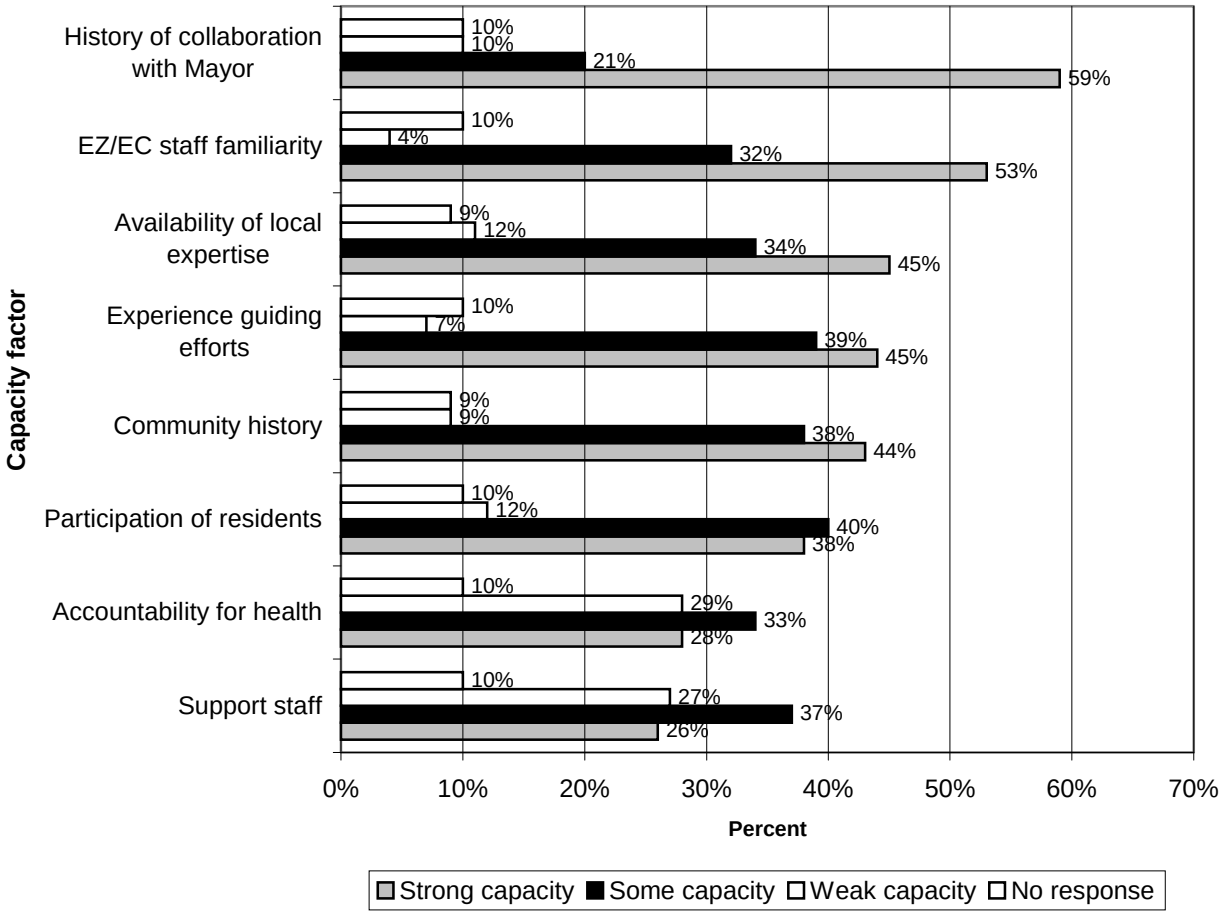
Figure 12. Attendance at last advisory group meeting (N=104)



6. Technical assistance

Responding EZ/ECs reported strong capacity most frequently for the following health improvement planning activities: (1) EZ/EC staff familiarity with community issues, and (2) history of collaboration with the mayor. Areas of weakest capacity were: (1) support staff available for meeting planning, and (2) a planning body or person accountable for health in the EZ/EC (see Figure 13). Overall, respondents indicated important political, community, and staffing capacity for health improvement planning. Rural EZ/ECs more consistently reported "strong capacity" for factors of capacity than urban EZ/ECs (see Appendix 2, Table 48). Additionally, rural EZ/ECs more consistently reported a desire for all areas of technical assistance than urban EZ/ECs (see Appendix 2, Table 49).

Figure 13. Capacity factors of health improvement planning (N=119)

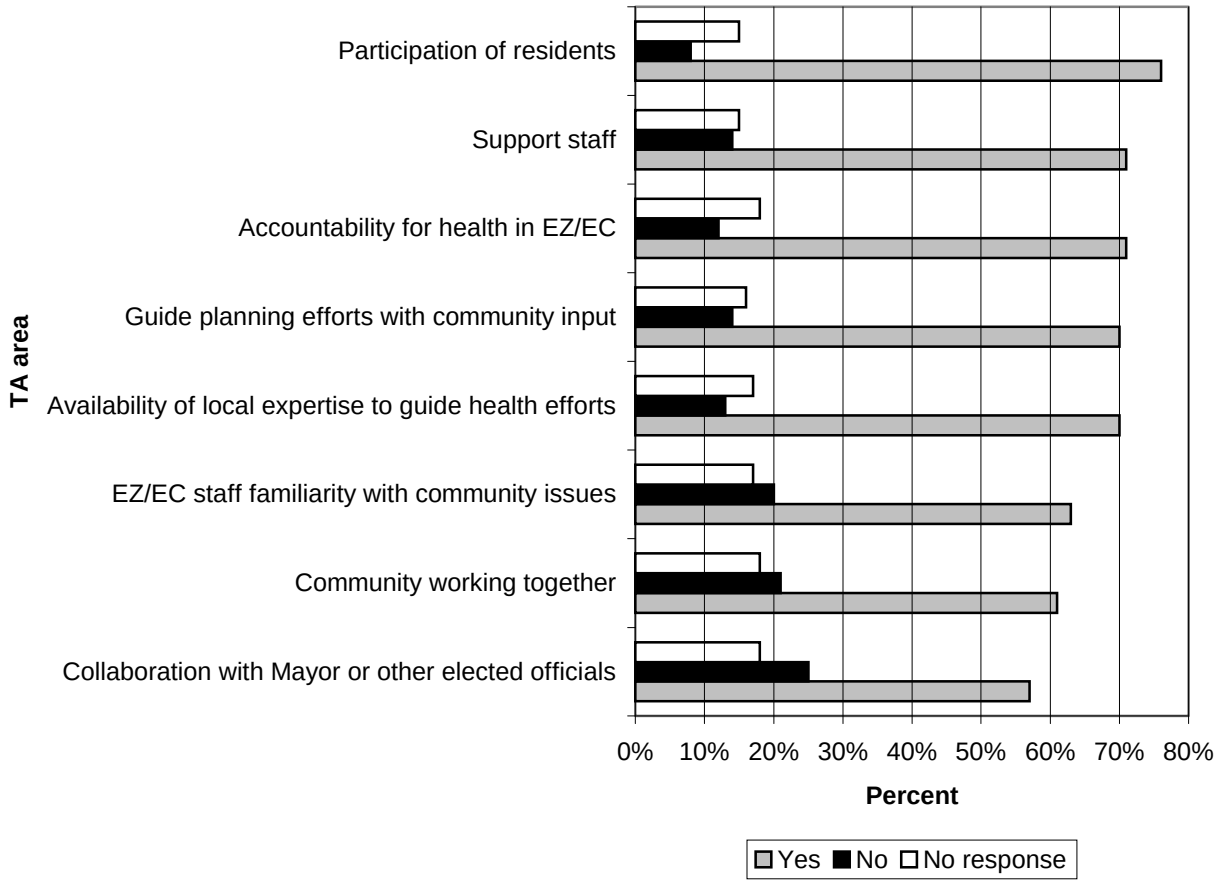


EZ/ECs interest in technical assistance corresponded with their capacity for various health improvement planning efforts (see Figure 14). They correspond with the areas reported as weak capacity and with the areas where EZ/ECs reported experience, most likely building on what they already know. EZ/ECs most frequently reported that they would use technical assistance in the following areas:

- Participation of residents and community groups in EZ/EC-led activities (76%)
- Support staff for meeting planning, minutes, and mailings (71%)
- A planning body or person accountable for health in the EZ/EC (71%)
- Guiding health planning efforts with community input (70%)
- Local expertise to guide the EZ/EC health efforts (70%)

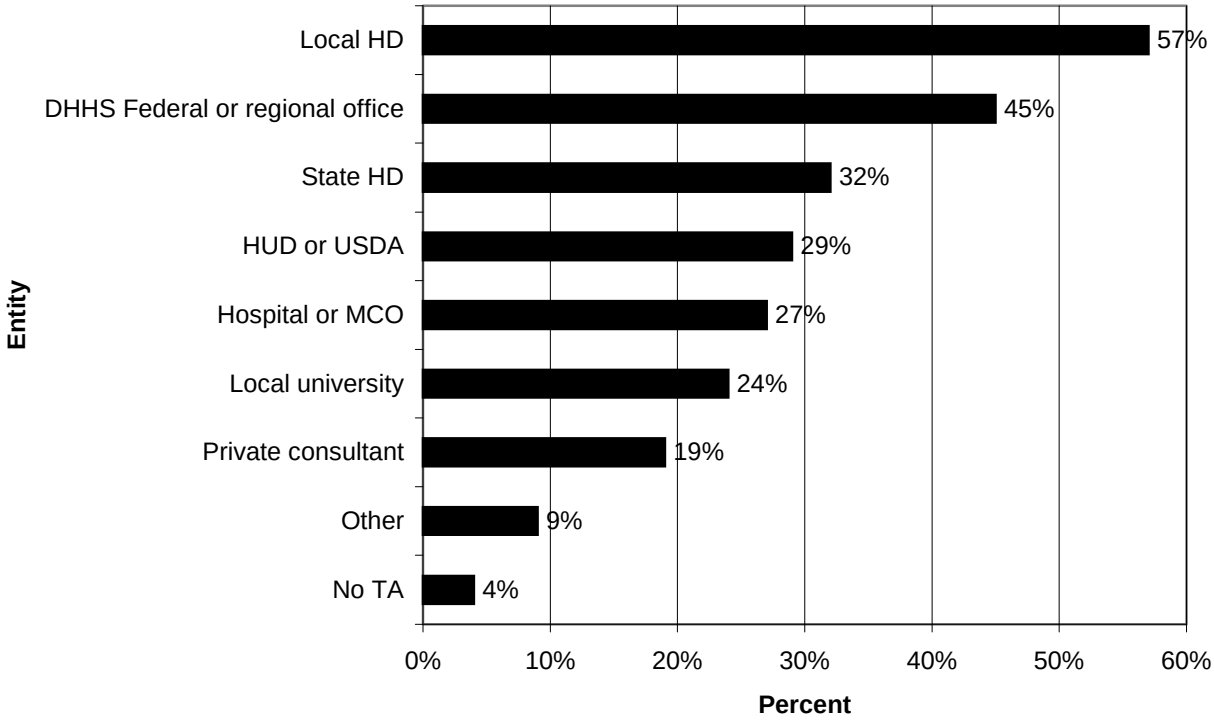
More than half (57%) of the EZ/ECs said they would use technical assistance working with their mayors or other elected officials to bring about health improvements in their communities.

Figure 14. Technical assistance EZ/ECs would use if offered (N=119)



A majority of responding EZ/ECs (57%) reported that they would like technical assistance from their local health departments. Slightly less than half (45%) said that they would look to HHS Federal or regional offices for technical assistance (see Figure 15). About one-third (32%) of EZ/ECs would use assistance from a state health department.

Figure 15. Who EZ/ECs would like technical assistance from (N=119)



Recommendations

The responses to the health capacity survey show that many EZ/ECs already have the basic level of readiness to undertake and sustain successful health improvement efforts and to benefit from technical assistance. Maximizing the capacity of the EZ/ECs to engage in health planning and health improvement activities will facilitate meeting the nation's goal to eliminate health disparities.

The following recommendations to HHS address the key objectives of this survey—to assess EZ/EC health planning capacity and technical assistance needs. These recommendations are based on the survey findings and are consistent with the lessons learned from the EZ/EC Health Benchmarking Demonstration Project. They reflect the professional judgement of the PHF project team and suggest ways to build on existing EZ/EC health capacities reported by the 119 respondents.

- Encourage EZ/EC leaders to explicitly make health issues one of their top priorities. EZ/EC leaders who reported health issues as among their top priorities also reported the most experience in health planning activities.

- Promote the formation of health specific advisory structures in EZ/EC sites. It is apparent from the survey that organizational structures such as health advisory groups are linked to accountability for health, involvement in health activities, and integration of health initiatives in economic development plans. An important focus of future efforts could be follow-up with EZ/ECs that have health specific advisory groups to probe why they work, how they are structured, and how they should function.
- Encourage EZ/EC leaders to form links with local health departments, and vice versa, to work on health improvement efforts. There already are mechanisms and activities in place that the Federal government could use to promote these linkages such as EZ/EC workshops. Also, EZ/EC leaders could be encouraged to contact their local health departments and invite health agency representatives (the least cited participants in EZ/EC advisory group meetings) to attend meetings and planning sessions. To encourage local health departments to reach out to EZ/ECs, the National Association of County and City Health Officials (NACCHO) and other public health agency associations could promote EZ/EC health improvement opportunities to their members. Information that EZ/EC survey respondents stated specifically that they would like assistance from local health departments may further encourage those health departments to contact EZ/ECs to offer assistance. In addition, inform public health agencies about EZ/EC strengths that can fill gaps in community-wide health improvement capacity, such as EZ/ECs inroads with Mayors and businesses—this knowledge may motivate them to contact EZ/EC directors, particularly if they feel welcome to do so.
- Base technical assistance to a majority of EZ/ECs on the formation of and participation in dynamic partnerships to address specific health issues in which EZ/ECs already have interest and experience. In addition, provide targeted assistance to the minority of EZ/ECs that report that they see themselves organizing broad health improvement planning efforts in the next three years.
- Adopt a two-tiered technical assistance strategy to further develop and reinforce EZ/EC strengths and to develop weak areas. Respondents indicated desires for assistance at both ends of the capacity continuum (i.e., areas for which EZ/ECs reported the strongest and weakest capacity).
    - As a first step, identify specific health improvement activities that match current EZ/EC health planning capacities and build upon self-assessed strengths, such as a history of collaboration with their mayors and a knowledge of their own communities.
    - As a longer-term strategy, build EZ/EC health planning capacities in areas where they have identified their own weaknesses, such as participation of residents in EZ/EC activities, availability of support staff, and accountability for health in the EZ/EC.

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Appendix 1: Survey and Letters

Advanced Notice Letter

[Date]

[Name and address of EZ/EC respondent]

[Dear…]

The Office of the Assistant Secretary for Planning and Evaluation is embarking on a study of Empowerment Zones and Enterprise Communities (EZ/EC) and their capacity to integrate health planning into economic development plans. We have asked the Public Health Foundation (PHF), a non-profit group based in Washington, D.C., to assist us in this study. In approximately 10 days, you will receive a survey on EZ/EC's and their capacity to integrate health planning into economic development plans. The objectives of the study are to identify and assess EZ/EC experiences with health activities and their capacity to conduct a health improvement planning process.

Your participation in this study would be greatly appreciated. The results will help the Department of Health and Human Services to build on EZ/EC successes and determine the most useful types of technical assistance to enhance EZ/EC health improvement planning efforts.

Further details will be included with the survey. If you have any questions, please feel free to contact Dianna Conrad, a member of the research team at PHF at (202) 898-5600, ext. 3003.

Thank you in advance for your assistance!

Sincerely,

Margaret Hamburg, M.D.
Assistant Secretary for Planning and Evaluation

Cover Letter

[Date]

[Name and address of EZ/EC respondent]

[Dear…]

The Office of the Assistant Secretary for Planning and Evaluation is embarking on a study of Empowerment Zones and Enterprise Communities (EZ/EC) and their capacity to integrate health planning into economic development plans. We have asked the Public Health Foundation (PHF), a non-profit group based in Washington, D.C., to assist us in this study. I am writing to invite your participation. The objectives of the study are to identify and assess EZ/EC experiences with health activities and their capacity to conduct a health improvement planning process.

A survey is enclosed and is being sent to all EZ/EC sites throughout the United States. The results of the survey will be summarized in a report. You may receive a summary of results by writing "copy of results requested" on the back of the return envelope.

Although we hope you will participate in this study, it is entirely voluntary. If you wish to participate, please complete and return the survey in the enclosed, postage-paid envelope by June 28, 2000 or fax to Dianna Conrad, a member of the research team at PHF at (202) 898-5609. If you prefer not to participate, please send the survey back blank. If you have any questions about this survey, please contact Dianna Conrad at (202) 898-5600, ext. 3003 or via e-mail at dconrad@phf.org.

Your cooperation is greatly appreciated!

Sincerely,

Margaret Hamburg, M.D.
Assistant Secretary for Planning and Evaluation

EZ/EC Health Improvement Capacity Survey

Instructions

This survey will help determine the capacity of Empowerment Zones and Enterprise Communities (EZ/EC's) to integrate health planning into their economic development plans. The survey has an identification number so that we may check your EZ/EC's name off our mailing list when we receive your completed survey. Results will be reported without identifying information, however, identifiers will be shared with ASPE or other federal agencies so that they may follow-up with sites on an individual basis regarding technical assistance or other needs you may indicate in this survey.

Although we hope you will participate in this survey, it is entirely voluntary and cannot affect your funding. If you wish to participate in the survey, please complete and return the survey in the enclosed, postage-paid envelope. The survey will take approximately 15 - 20 minutes to complete. We ask that you read the questions carefully, as some questions ask for one response and others ask for multiple responses. For multiple choice, please circle the number that corresponds with the most appropriate response(s). If you prefer not to participate, please send the survey back blank.

Paperwork Reduction Act Statement

A federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Public reporting burden for this collection of information is estimated to vary from 15 to 20 minutes with and average of 17 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the necessary data, and completing and reviewing the collection of information.

Definitions

This survey asks about health issues and health improvement efforts or activities in the EZ/EC. Examples of health issues include residents' access to quality health care, health disparities among disadvantaged populations, HIV/AIDS, safe environments, mental health, substance use, and the availability of healthful foods.

Health improvement efforts or activities include any planned activities to address health issues and build healthy communities. Health promotion campaigns, referral programs, health care provider training, health policy advocacy, community health assessment and planning projects, and the provision of screening and services are examples of many possible health improvement efforts.

Community advisory groups are bodies formally organized by the EZ/EC and charged with gaining input from the EZ/EC citizens, businesses or other groups.

Name of Person Completing Survey

The purpose of gathering this information is to determine who is filling out the survey and to potentially follow-up, if needed, on certain survey questions.

Name:_____

EZ/EC Position:

1 Appointed director

2 Acting director

3 Other (specify title): _____

May we contact you if we have questions about your responses?

1 Yes

2 No

Q1.a. Does the EZ/EC <u>currently</u> have any general community advisory groups?

1 Yes

2 No *(Skip to # Q2)*

b. Do the groups have authority to make decisions that determine EZ/EC activities?

1 Yes

2 No

c. Do they meet regularly? *(At least quarterly)*

1 Yes

2 No

d. At the last meeting of one or more of the advisory groups, did any of the following people attend?

	Yes	No
Individual(s) from EZ/EC neighborhood(s)	1	2
Business representative(s)	1	2
Health agency representative(s)	1	2
Representative(s) from community-based organizations (such as social service agencies or mental health agencies)	1	2
Representative(s) from executive office of local government	1	2
Representative(s) from other community groups (such as faith community or civic groups)	1	2

e. Does the EZ/EC have a health-specific advisory group?

1 Yes

2 No

3 Not sure

Q2.a. Are you on a first name basis with someone at your local health department?

1 Yes

2 No

b. If yes, on average, how often have you discussed health issues in the EZ/EC with this person?

1 Weekly

2 Monthly

3 Quarterly

4 Once a year

5 Never

Q3.a. Are there business people that you can call for advice about EZ/EC issues?

1 Yes

2 No

b. Have you ever had a conversation about health issues with EZ/EC business people?

1 Yes

2 No

Q4.a. Does the local area that includes the EZ/EC have a written health plan, <u>issued within the past 5 years</u>, that specifies goals, target objectives, and strategies to improve health?

1 Yes

2 No *(Skip to # Q3)*

3 Not sure *(Skip to # Q3)*

b. Who issued the plan?

1 Local health department (such as city or county)

2 State health department

3 EZ/EC

4 Executive office of local government (such as mayor or county executive)

5 Other local government body (such as city or county council or board of commissioners)

6 Local hospital or managed care organization

7 Other: _____

8 Not sure

c. What geographic area does the health plan cover?

1 EZ/EC only

2 An area larger than the EZ/EC

3 An area smaller than the EZ/EC

4 Not sure

d. Does the plan target the elimination of racial and health disparities?

1 Yes

2 No

3 Not sure

e. Did the EZ/EC (staff or advisory groups) have input into this plan?

1 Yes

2 No

3 Not sure

Q5. Who is in charge of overseeing health planning and monitoring for the EZ/EC?

1 Local health department (such as city or county)

2 State health department

3 EZ/EC office

4 Executive office of local government (such as mayor or county executive)

5 Other local government body (such as city or county council or board of commissioners)

6 Local hospital or managed care organization

7 Other: _____

8 Not sure

Q6. a. Is there regularly published information on local health statistics for an area that includes the EZ/EC that has been compiled in the last three years?

1 Yes

2 No *(Skip to # Q7)*

3 Not sure *(Skip to # Q7)*

b. Is the report relevant to your EZ/EC information needs?

1 Yes *(Skip to # Q7)*

2 No

3 Not sure *(Skip to #Q7)*

c. Why does the report NOT meet EZ/EC information needs? _____

_____

Q7. Which of the following statements <u>best</u> describes your own interest in addressing health issues in the EZ/EC?

1 Addressing health issues interests me and is among my top priorities.

2 Addressing health issues interests me but is not my top priority.

3 I am not interested in addressing health issues in the EZ/EC.

4 I have no opinion about addressing health issues in the EZ/EC.

Q8.a. <u>In the past 3 years</u>, has the EZ/EC identified specific health issues as important to the EZ/EC?

1 Yes

2 No *(Skip to # Q9)*

b. If yes, how did the EZ/EC identify these specific issues? *(Choose <u>all</u> that apply.)*

1 Community input (such as surveys, meetings, focus groups)

2 EZ/EC consultation with health experts

3 Acquisition of local health statistics

4 Comparison of EZ/EC health statistics to those of surrounding communities

5 Review of existing strategic health plans for an area including the EZ/EC

6 Decisions of mayor or other elected officials

7 EZ/EC identified as target area for health initiatives by state or local health department

8 Availability of resources

9 Other: _____

Q9. Please consider the following health issues. Indicate on a scale of 1 – 3 how important each issue is to the EZ/EC and if the issue has been formally assessed.

<u>Type of Health Issue</u>	**Very Important**	**Important**	**Not Important**	**Check here if formally assessed**
Primary care services (such as regular check-ups)	1	2	3	
Preventive services (such as pap smears, mammograms or immunizations)	1	2	3	
Health promotion programs (such as smoking cessation or violence prevention classes)	1	2	3	
Private and/or public health insurance	1	2	3	
Substance abuse treatment	1	2	3	
Mental health services	1	2	3	
Health policies (such as environmental, commercial development, or employer policies related to health)	1	2	3	
Specific diseases or conditions (such as cancer, HIV, diabetes, or heart disease)	1	2	3	
Behaviors that affect health (such as exercise or nutrition)	1	2	3	
Environmental health (such as water and air quality)	1	2	3	
Barriers for special populations (such as lack of education, language barriers, or cultural competence in health services)	1	2	3	

Q10. a. Has the EZ/EC included any specific health initiatives in economic development initiatives?

(Examples of such initiatives may be job training for health related jobs or tax incentives for health maintenance organizations moving into the EZ/EC.)

1 Yes

2 No *(Skip to #Q11)*

b. Please describe: _____

Q11. a. Has the EZ/EC targeted any special populations for health improvement efforts?

1 Yes

2 No

b. If yes, which ones? ***(Choose <u>all</u> that apply.)***

1 Racial or ethnic minority populations

2 Youth or children

3 Older adults

4 Males or females

5 Uninsured workers

6 Persons for whom English is not their native language

7 Migrant or undocumented workers

8 Other: _____

Q12. a. Has the EZ/EC participated in or planned a health improvement activity <u>in the past year</u>?

1 Yes

2 No *(Skip to # Q13)*

b. What was the <u>main</u> issue addressed in recent EZ/EC health improvement activities?

_____

c. Consider each of the following health improvement activities. On a scale of 1 – 3, how much experience does the EZ/EC have with each?
(1 = much experience, 2 = some experience, and 3 = little or no experience)

_____ **Identify or assess** EZ/EC health needs

_____ **Facilitate or mobilize** partnerships to address identified EZ/EC health issues

_____ **Organize** broad community health improvement planning efforts

_____ **Deliver** health improvement programs for the community

_____ **Set policies** within the EZ/EC that support a healthy workforce and community

_____ **Participate** in health initiatives led by other groups or government offices

_____ **Fund** health programs in the EZ/EC

_____ **Advocate** for health policies, health programs and services to address EZ/EC needs

_____ **Recruit** EZ/EC residents to participate in health efforts

_____ **Other:** _____

Q13. Think about what you would like to see the EZ/EC do in the <u>next three years</u> to improve health. On a scale of 1 – 3, how much effort do you think the EZ/EC is likely to invest in each of the following health improvement activities?
(1 = much effort, 2 = some effort, and 3 = little or no effort)

_____ **Identify or assess** EZ/EC health needs

_____ **Facilitate or mobilize** partnerships to address identified EZ/EC health issues

_____ **Organize** broad community health improvement planning efforts

_____ **Deliver** health improvement programs for the community

_____ **Set policies** within the EZ/EC that support a healthy workforce and community

_____ **Participate** in health initiatives led by other groups or government offices

_____ **Fund** health programs in the EZ/EC

_____ **Advocate** for health policies, health programs and services to address EZ/EC needs

_____ **Recruit** EZ/EC residents to participate in health efforts

_____ **Other**: _____

Q14. Think about what it might take for the EZ/EC to convene and lead a successful health improvement planning effort, involving a wide range of community partners.

a. Please consider the following factors related to capacity to carry out health improvement planning efforts. Please indicate whether your EZ/EC has weak capacity, some capacity, or strong capacity for each factor.

	Strong Capacity	Some Capacity	Weak Capacity
Support staff available for meeting planning, minutes, and mailings	1	2	3
Participation of residents and community groups in EZ/EC-led activities	1	2	3
A history of collaboration with the Mayor or other elected official on EZ/EC initiatives	1	2	3
Community history of working together	1	2	3
Experience guiding planning efforts with community input	1	2	3
Local expertise available to guide the EZ/EC in health efforts	1	2	3
Planning body or person is accountable for health in the EZ/EC	1	2	3
EZ/EC staff familiar with community issues	1	2	3
Other: _____	1	2	3

b. Would you use technical assistance in the area if offered?

	Yes	No
Support staff for meeting planning, minutes, and mailings	1	2
Participation of residents and community groups in EZ/EC-led activities	1	2
A history of collaboration with the Mayor or other elected official on EZ/EC initiatives	1	2
Community history of working together	1	2
Experience guiding planning efforts with community input	1	2
Local expertise available to guide the EZ/EC in health efforts	1	2
Planning body or person is accountable for health in the EZ/EC	1	2
EZ/EC staff familiar with community issues	1	2
Other: _____	1	2

Q15. From whom would you most like technical assistance with health improvement planning efforts? *(Choose up to three.)*

1 Local health department

2 Hospital or managed care organization

3 State health department

4 Housing and Urban Development or United States Department of Agriculture

5 Department of Health and Human Services Federal or regional offices

6 Private consultant

7 Local university

8 Other: _____

9 I would not like technical assistance with health efforts.

Q16. Which of the following resources could you see yourself making available in the next year to improve health in the EZ/EC?

1 EZ/EC staff time

2 EZ/EC financial resources

3 EZ/EC staff time and financial resources

4 Other: _____

5 None of these

Your contribution to this effort is greatly appreciated!

Please return your completed survey in the enclosed postage paid envelope or fax to Dianna Conrad at the Public Health Foundation, (202) 898-5609.

Reminder Postcard

Recently, we sent you a survey about health planning in Empowerment Zones and Enterprise Communities. If you have already returned the survey, please accept our sincere thanks. If you have not responded and you have some questions about the survey or if you did not receive the survey or it was misplaced, you may contact Dianna Conrad, a member of the research team at the Public Health Foundation at (202) 898-5600, ext. 3003 or via e-mail, dconrad@phf.org. Please return completed surveys by June 28, 2000.

Sincerely,

Margaret Hamburg, M.D.
Assistant Secretary for Planning and Evaluation

Second Mailing Cover Letter

August 15, 2000

[NAME]
[ADDRESS]

Dear :

As the Department of Health and Human Services (DHHS) regional office staff reminded you in a telephone call last week, we need your help! Please fill out the enclosed survey about Empowerment Zones and Enterprise Communities (EZ/EC) experiences with health activities. The Public Health Foundation (PHF) is conducting this survey for DHHS. By answering the questions, you will help DHHS build on EZ/EC successes and determine the most useful types of technical assistance to enhance health improvement efforts. Of course, what you have to say is private. Your answers will be part of a pool of information from EZ/EC directors.

We hope you will take this opportunity to tell us about your health care interests and activities. Most people find it takes only 20 minutes to answer these questions. Please return the completed survey in the enclosed postage-paid envelope by August 24, 2000 or fax to Dianna Conrad at PHF at (202) 898-5609. If you prefer not to participate, please return the blank survey.

If you have any questions, please contact Dianna Conrad at (202) 898-5600, ext. 3004 or via e-mail at dconrad@phf.org. Your cooperation is greatly appreciated!

Sincerely,

Ron Bialek
President
Public Health Foundation

TOC

Appendix 2: Data Tables

EZ/EC Health Planning Capacity Survey
Data Analysis[1]

Figure 1. Rural vs. Urban (n=119)

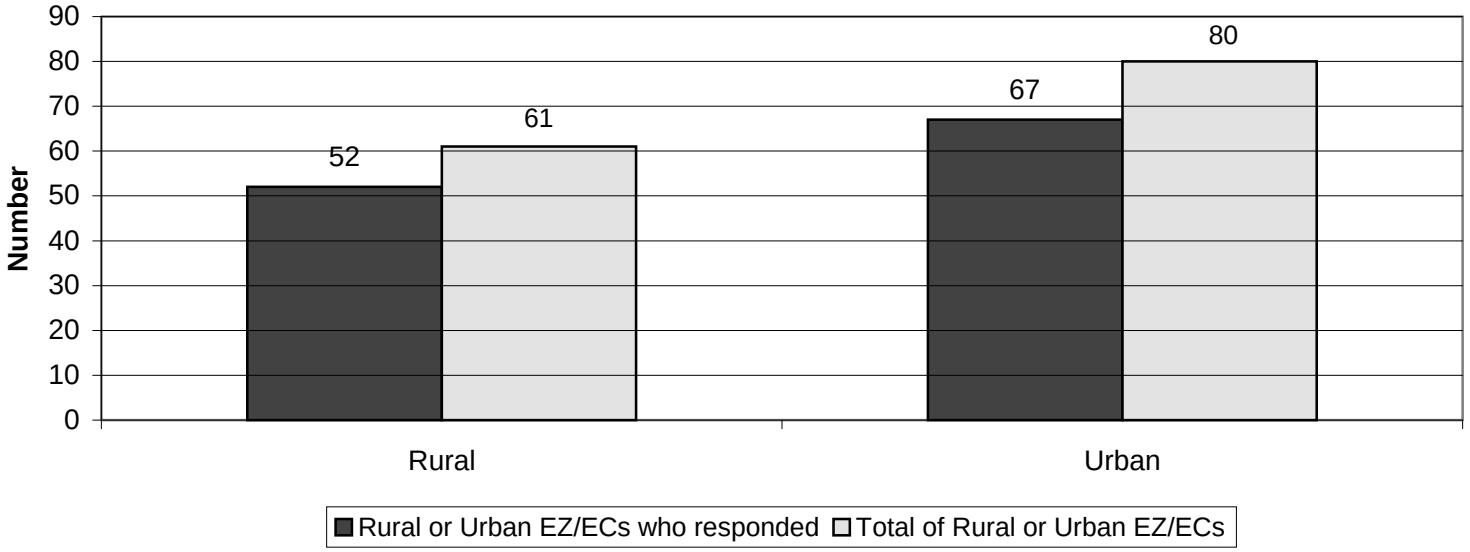
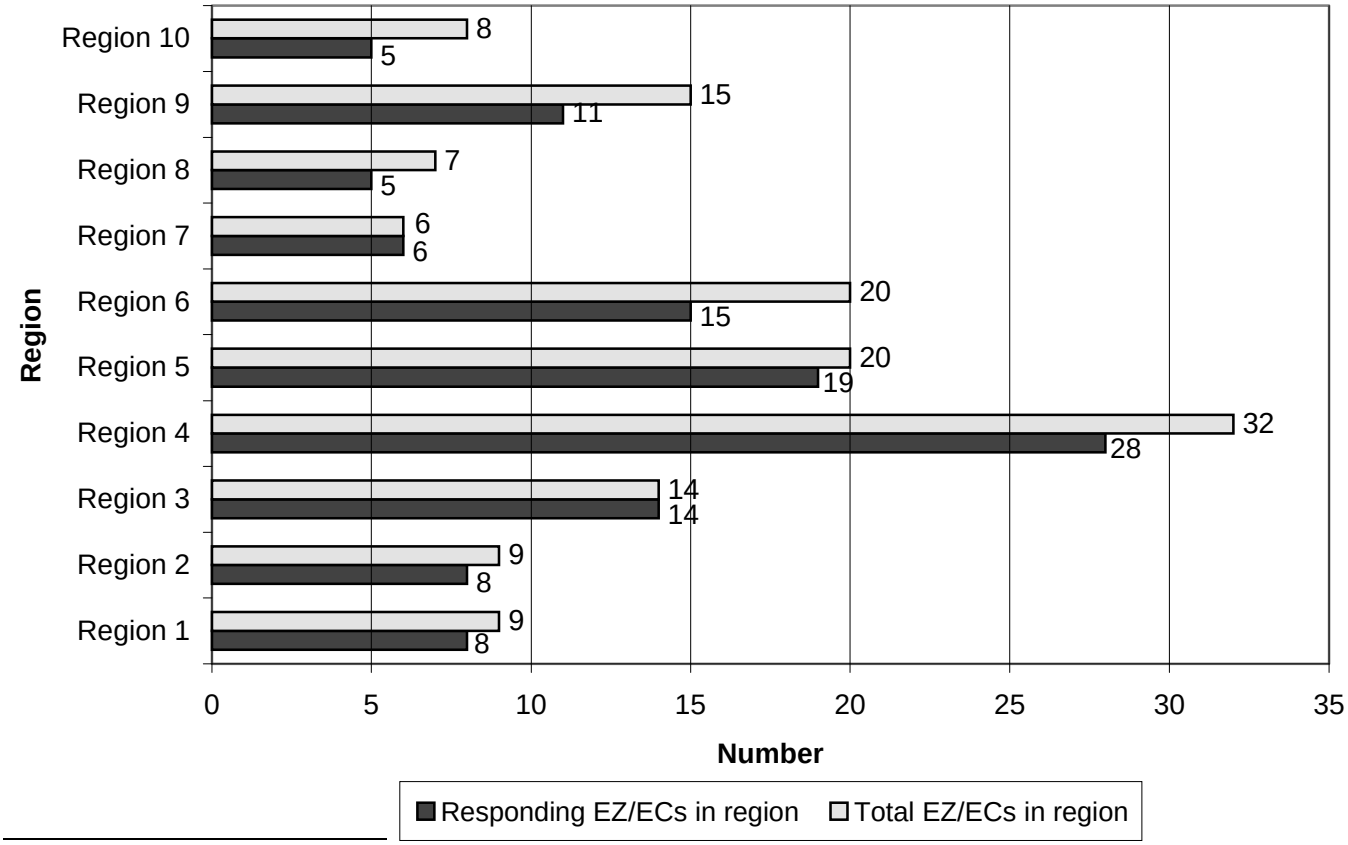


Figure 2. Respondents broken down by HHS region (n=119)



[1] For tables and graphs where respondents were asked to choose on answer but percentages do not equal 100%, this is due to rounding.

Figure 3. HHS Regions

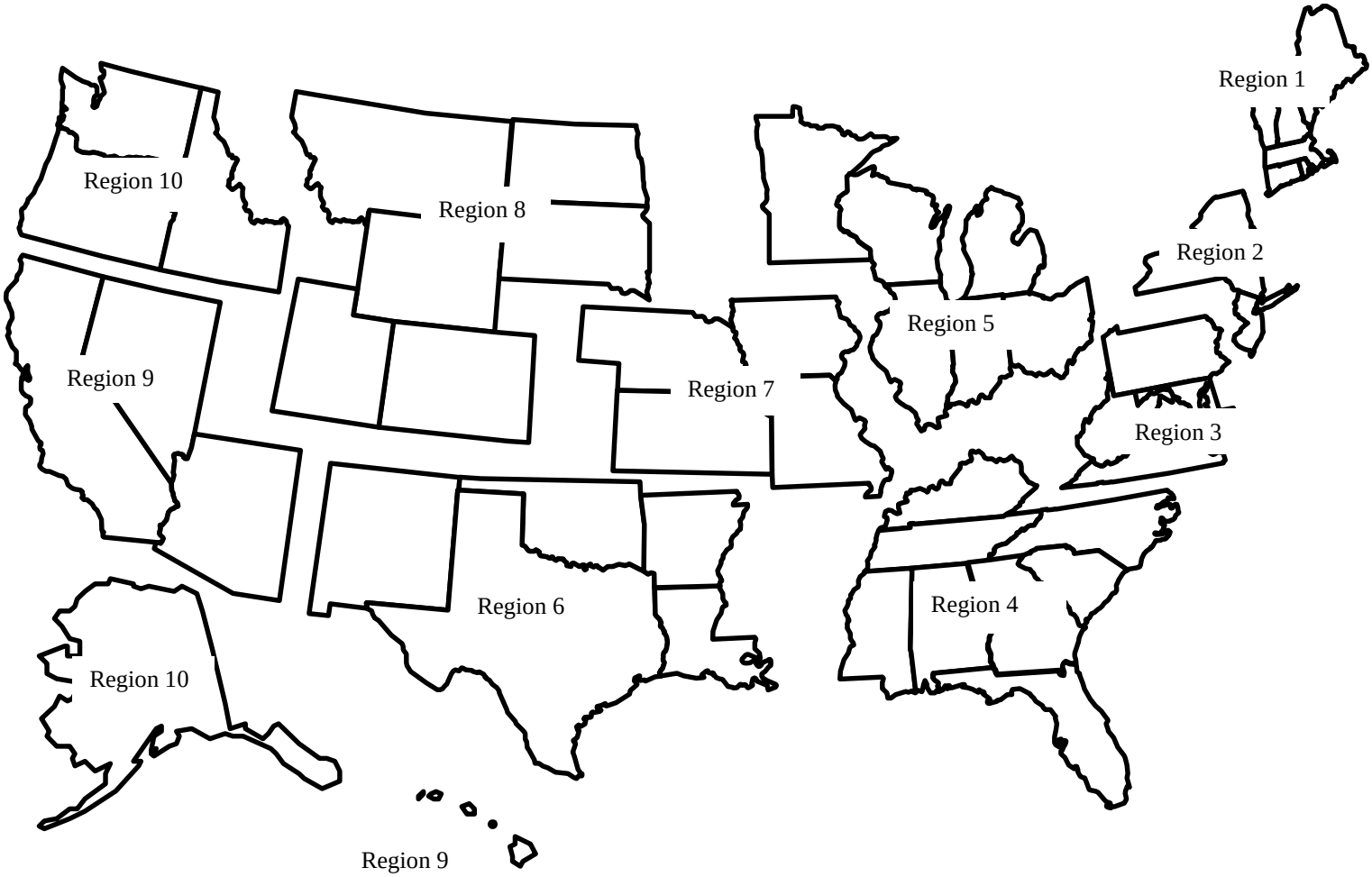


Table 1. (Q1 a, b, c)	**Yes**	**No**	**No Response**
General community advisory group (n=119)	89%	6%	5%
Authority to make decisions (n=106)	78%	22%	0%
Meet regularly (n=106)	93%	8%	0%

Figure 4. Attendance at last advisory group meeting (n=104) Q1d.

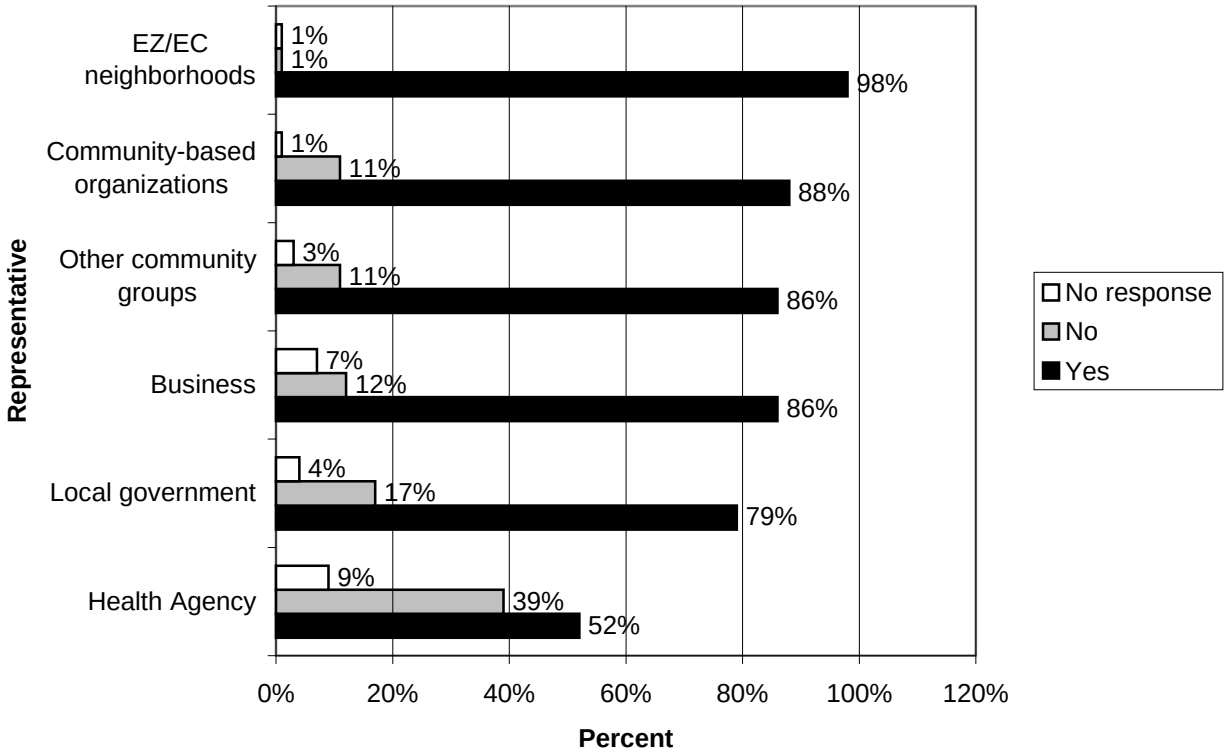


Table 2. (Q1 e)	**Yes**	**No**	**Not Sure**	**No Response**
Health-specific advisory group (n=106)	29%	68%	2%	1%

Table 3. (Q2 a)	**Yes**	**No**	**No Response**
First name basis with someone at local health department (n=119)	69%	27%	4%

Figure 5. How often health issues are discussed with the local health department (n=82) Q2 b.

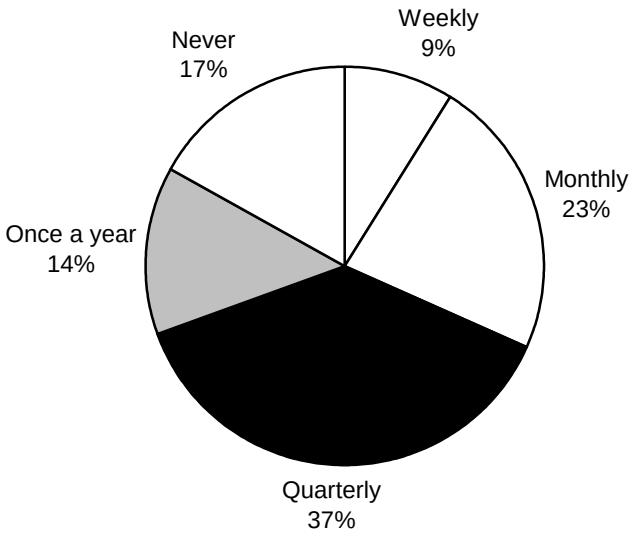
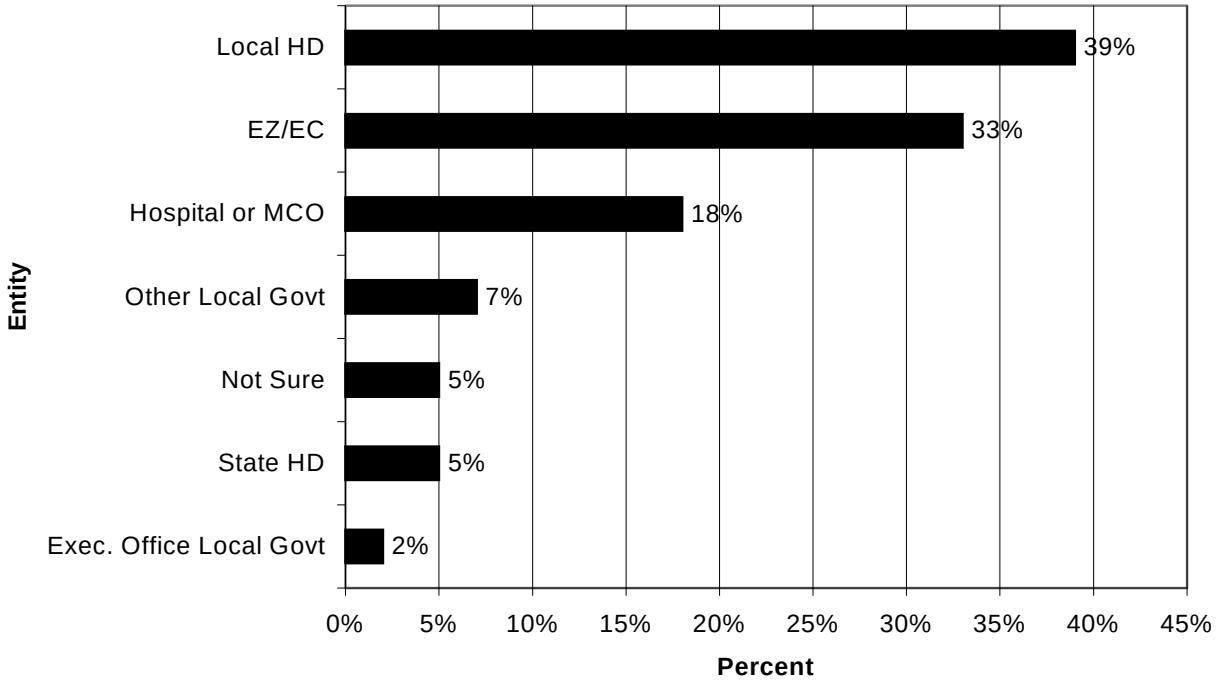


Table 4. (Q3 a, b)	**Yes**	**No**	**No Response**
Business people to call for advice (n=119)	90%	4%	6%
Conversation about health issues with business people (n=119)	57%	37%	6%

Table 5. (Q4 a)	**Yes**	**No**	**Not Sure**	**No Response**
Local area that includes EZ/EC has a written health plan issued within the past 5 years (n=119)	48%	16%	31%	5%

Figure 6. Organizations that EZ/EC reports issued written health plans for their areas (n=57) Q4 b.



- Other entities reported by respondents included: a Latino health institute, maternal and child health coalition, a W.K. Kellogg Foundation funded health project, local United Way, tribal council, a Federal qualified health center, community coalition, community public health and safety network, local community health center, district health department, a medical university's school of nursing, and a health advisory group.

Figure 7. Geographic area health plan covers (n=62) Q4 c.

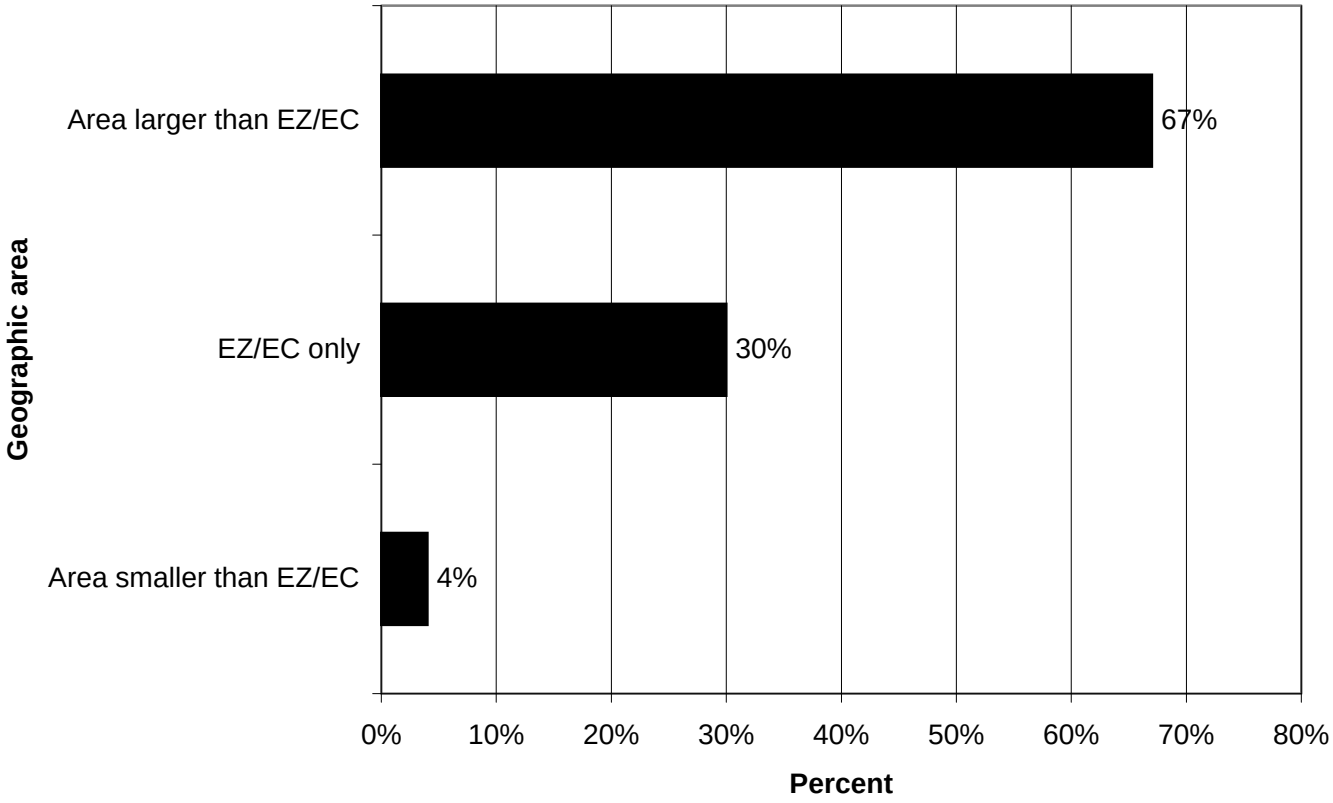
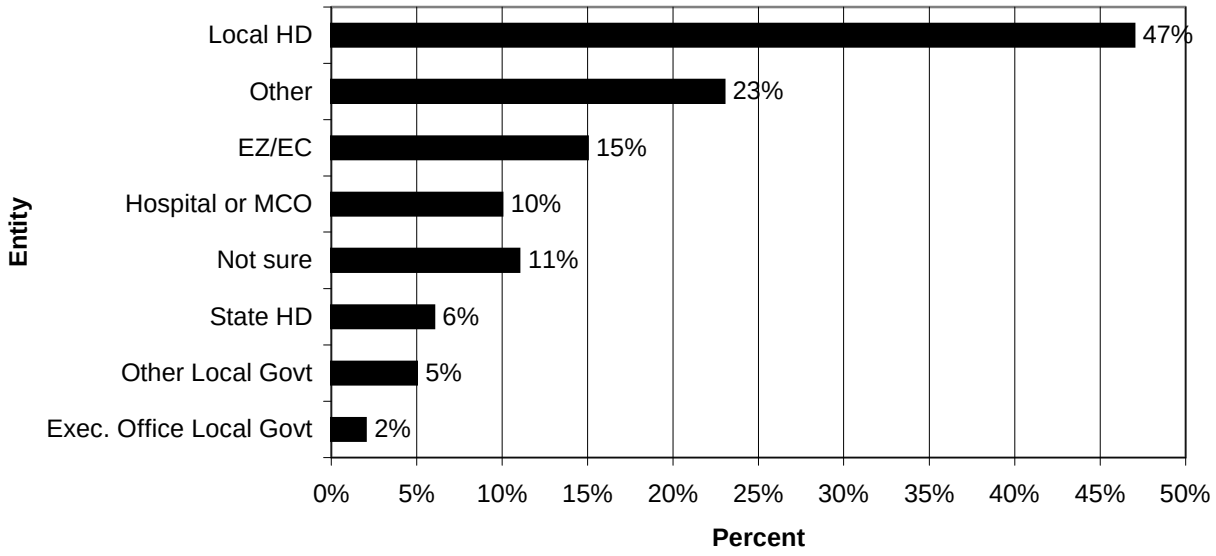


Table 6. (Q4 d, e)	**Yes**	**No**	**Not Sure**
Health plan targets elimination of racial and health disparities (n=57)	75%	7%	16%
EZ/EC had input into the health plan (n=57)	60%	32%	9%

Figure 8. Entity in charge of health planning and monitoring for the EZ/EC (n=119) Q5.



- Other entities respondents reported included: a Latino health institute, rural health advisory council, tribal projects within the EZ/EC, a W.K. Kellogg Foundation funded health project, consortium of health care organizations, tribal areas, community health organizations, health clinics, community health centers, Indian Health Service, and a school of nursing.

Table 7. (Q6 a, b)	**Yes**	**No**	**Not Sure**	**No Response**
There are regularly published information of local health statistics compiled in last 3 years (n=119)	50%	8%	36%	6%
Report relevant to EZ/EC information needs (n=59)	78%	8%	14%	NA

- Reasons the report did not meet EZ/EC information needs: data at less than county level are imprecise, the county profile information is not specific to individual census tracts.

Figure 9. Interest in addressing health issues in the EZ/EC (n=119) Q7.

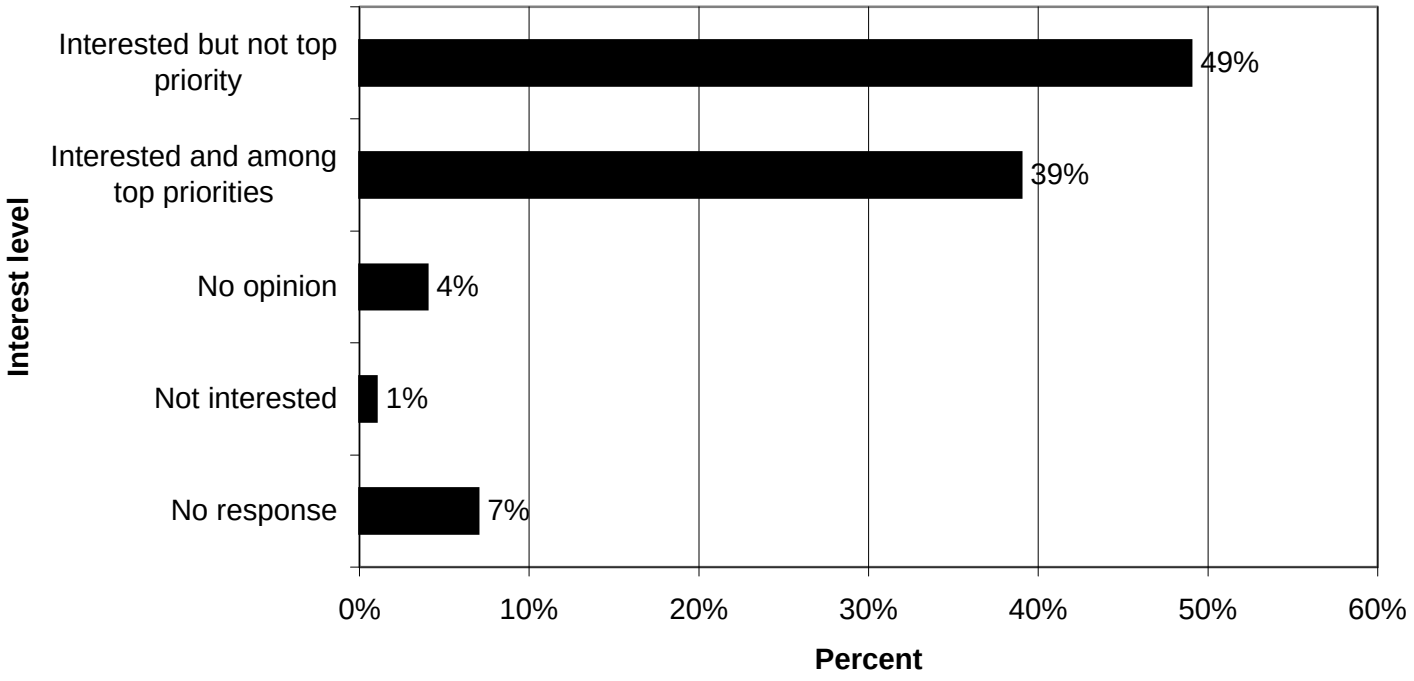
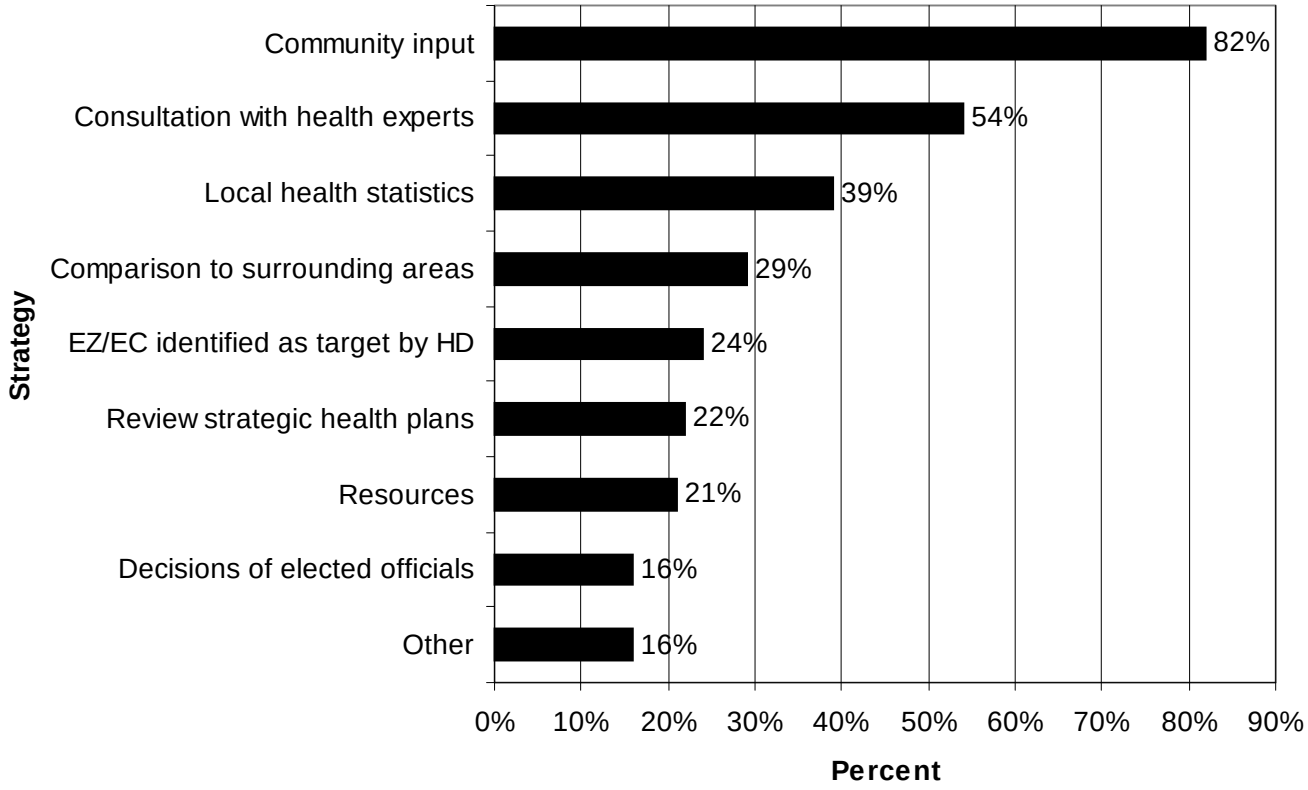


Table 8. (Q8 a)	**Yes**	**No**	**No Response**
EZ/EC identified specific health issues as important in the past 3 years (n=119)	64%	31%	5%

Figure 10. How EZ/EC identifies specific health issues (n=76) Q8 b.



- Other ways EZ/EC's identified specific issues: through a Latino health institute, and HHS funded benchmarking project, through an EC funded health clinic, the result of damage from a natural disaster, through a Federally qualified health center, through a community hospital, and a survey conducted by the EZ.

Figure 11. Importance of specific health issues (n=119) Q9.

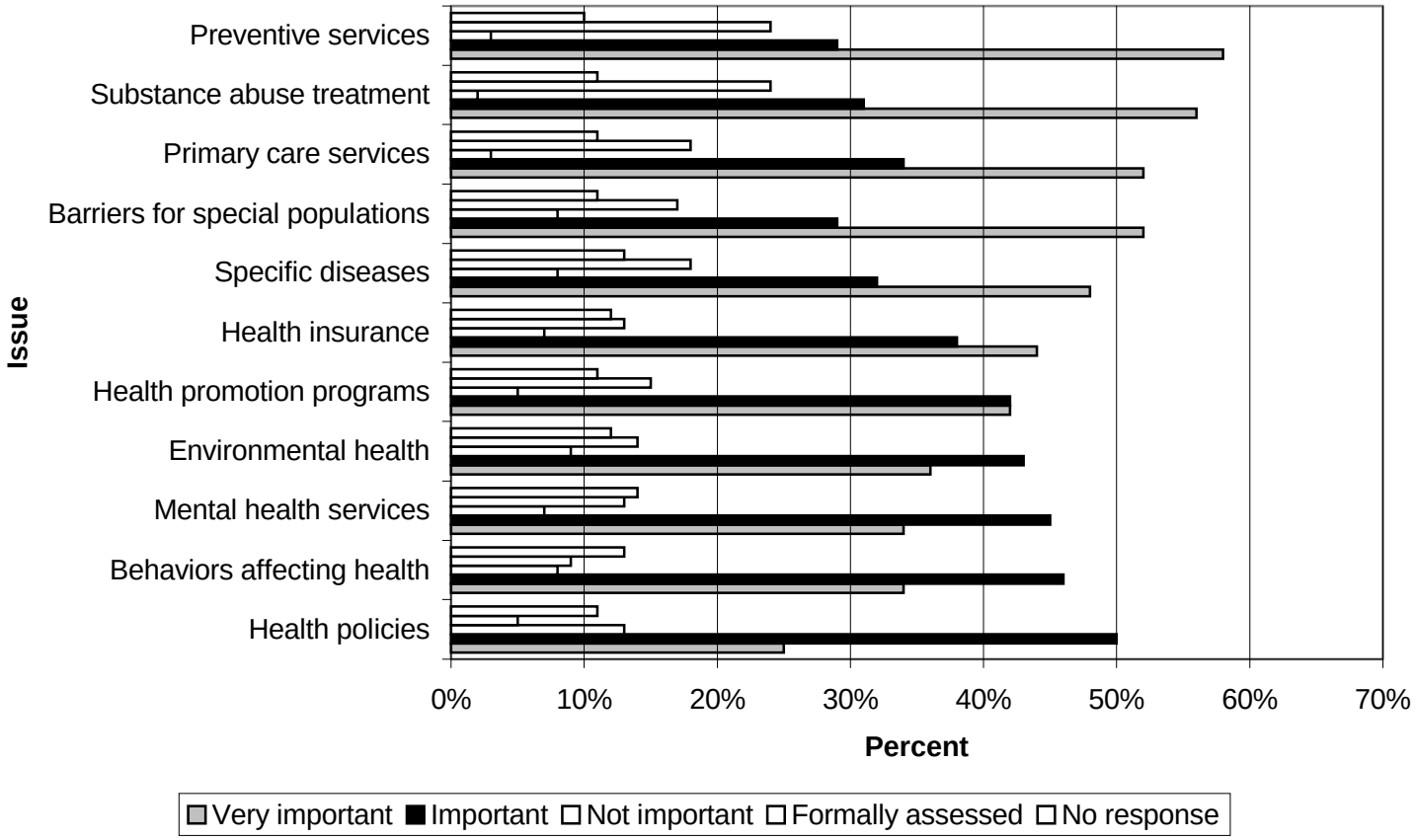
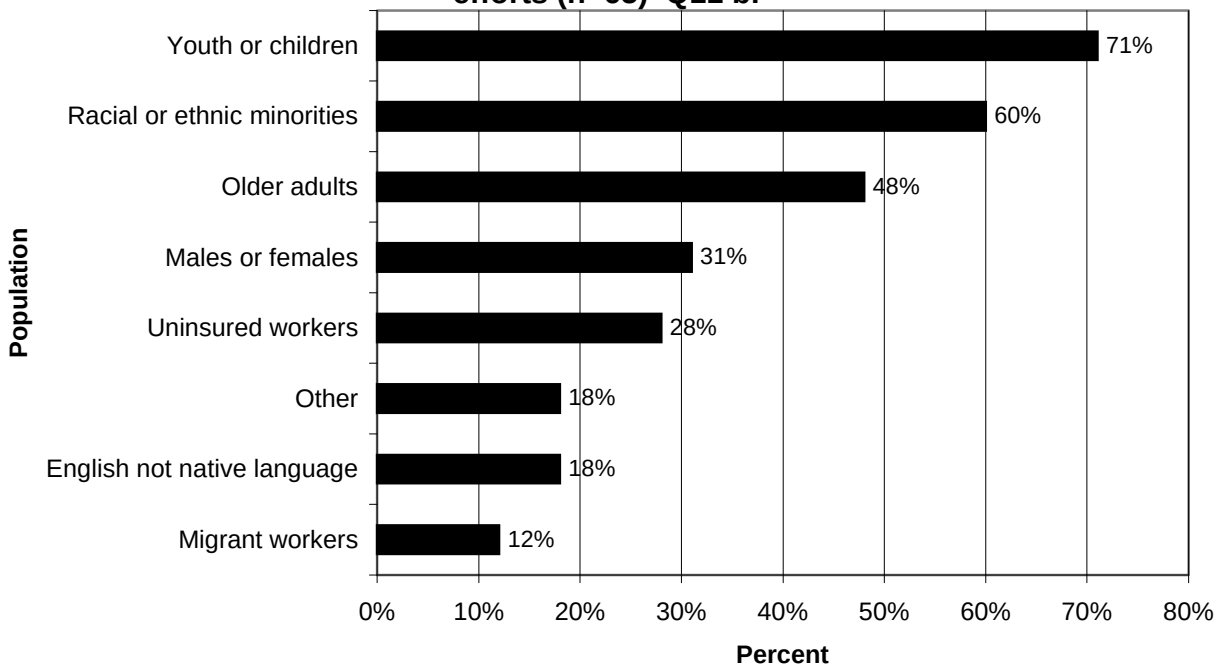


Table 9. (Q10 a)	**Yes**	**No**	**No Response**
Included health initiatives in economic development (n=119)	38%	50%	13%

- Examples of specific health initiatives included: training for home health aides, provided funding for Healthcare Fair in EC; provided funding for C.N.A. training; funded a tele-medicine study, job training with local hospitals, recruitment of dentists and doctors, establishment of health centers, Chemical Dependency Counselor or Certification Program, assist eldercare and assisted living centers, created Health Career Academy, about to begin with groundbreaking on rehabilitation hospital for paralysis, contracted with local nonprofit for medical training, housing, lead abatement, HIV/AIDS projects, healthcare for homeless, clinic in low-income neighborhood, provided customized training for surgical technicians, funding of HIV/AIDS travel van, exploring development of "medical academy" at local hospital, job training for health-related fields, improvement of EMS system, entrepreneurial training for health related businesses, screening and health prevention programs, job training/placement program at hospitals located in the EC.

Table 10. (Q11 a)	**Yes**	**No**	**No Response**
Targeted any special population for health improvement efforts (n=119)	55%	34%	11%

Figure 12. Special populations targeted for health improvement efforts (n=65) Q11 b.



- Other targeted populations mentioned include: the lesbian/gay/bisexual community, EC residents, patients with diabetes, kidney problems, hypertension, and substance abuse problems, high-risk groups, and farm workers.

Table 11. (Q12 a)	**Yes**	**No**	**No Response**
Participated in or planned health improvement activity in past year (n=119)	50%	43%	8%

- Main issues addressed in recent EZ/EC health improvement activities included: development of health improvement plan, asthma studies, HIV and well child programs, teen pregnancy prevention, education and prevention of common diseases, emergency services, healthcare access; HIV/AIDS education; healthcare for uninsured workers, elimination of health disparities, health fairs, substance abuse treatment, healthcare provider training and promotional campaigns, comprehensive regional health assessment, diabetes and kidney problems, accessibility of healthcare in rural areas, lead paint abatement, dental care, respite service for primary care givers of the elderly/handicapped, helped initiate a healthy start consortium, development of new, expanded health facilities, homelessness, tuberculosis, hypertension, hazardous materials/water contamination, health screening for older persons, nutrition, workforce development.

Figure 13. Level of experience with health improvement activities (n=59) Q12 c.

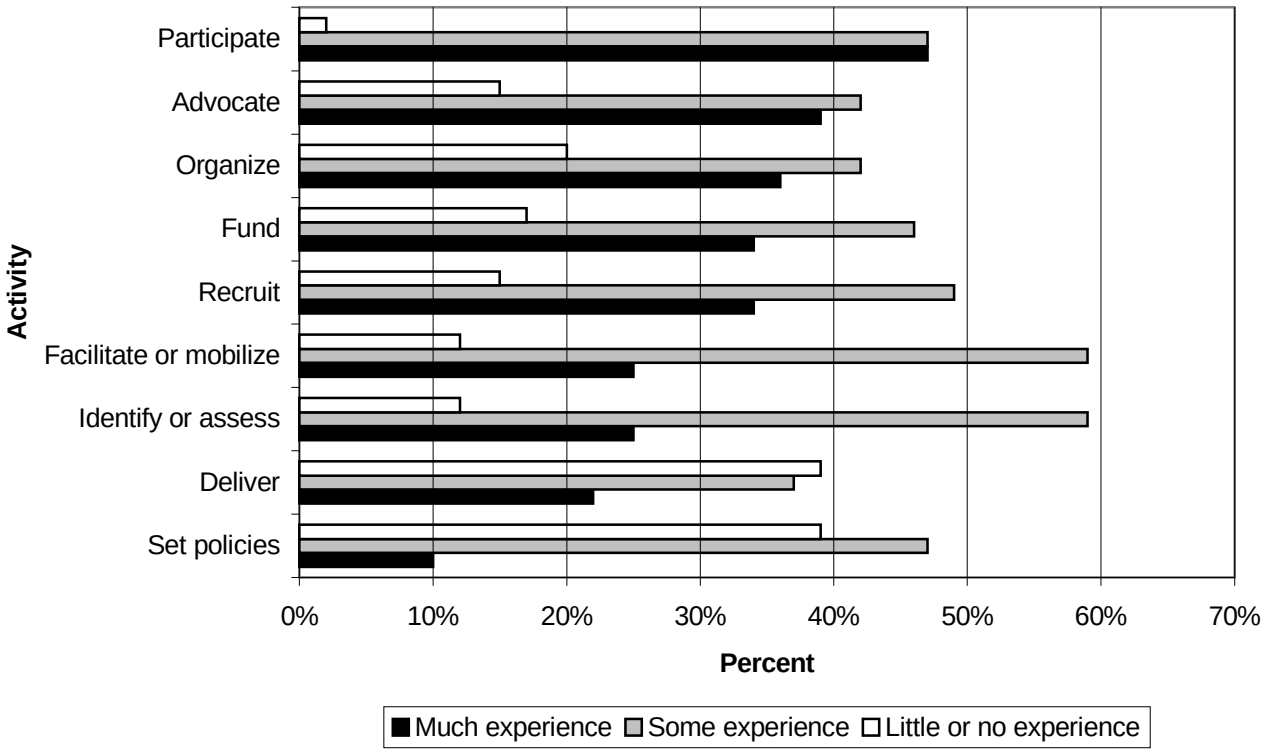


Figure 14. Level of effort EZ/EC is likely to invest in next three years (n=119) Q13.

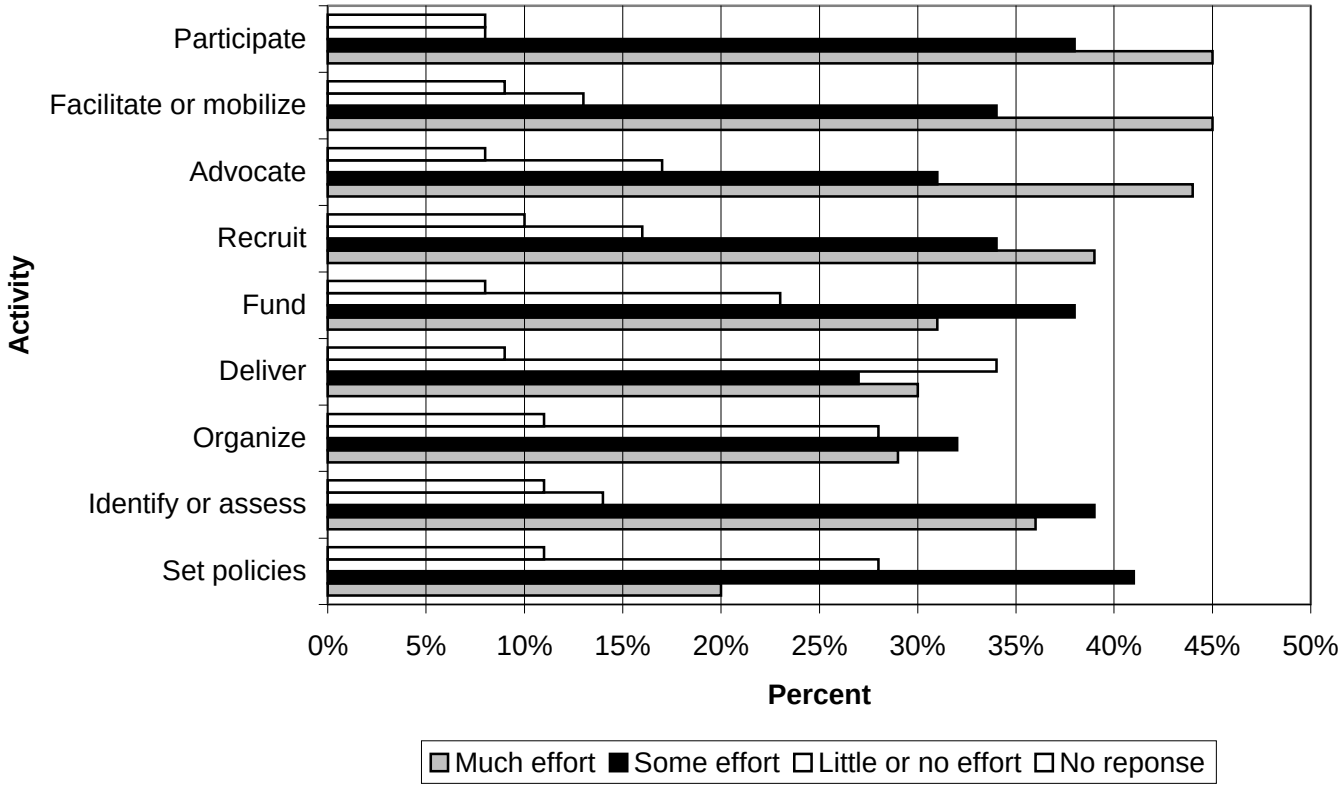
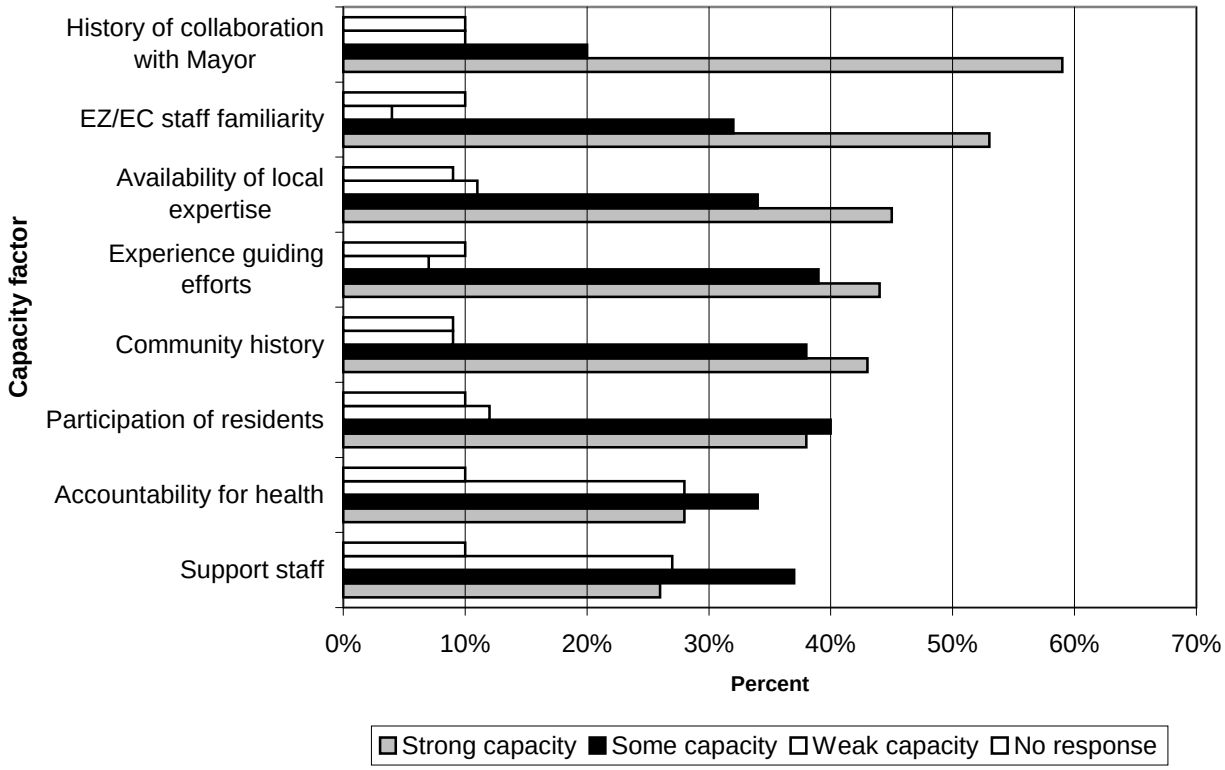
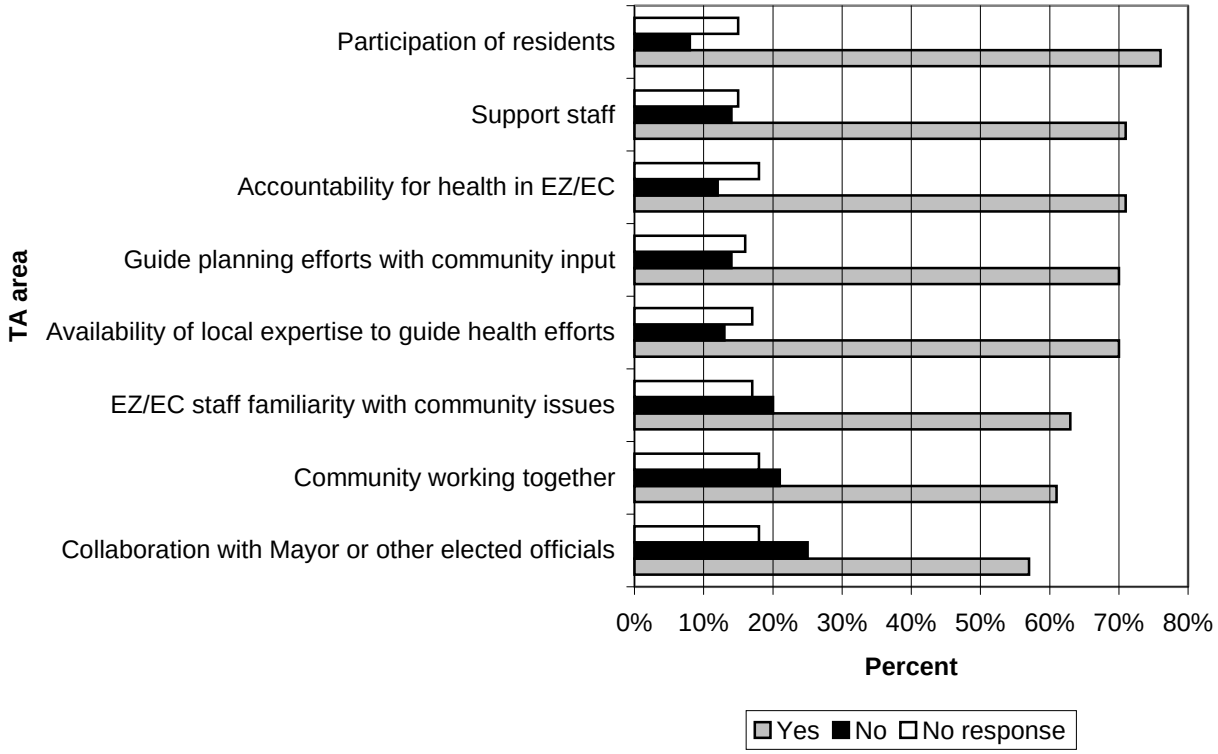


Figure 15. Capacity factors of health improvement planning (n=119) Q14 a.



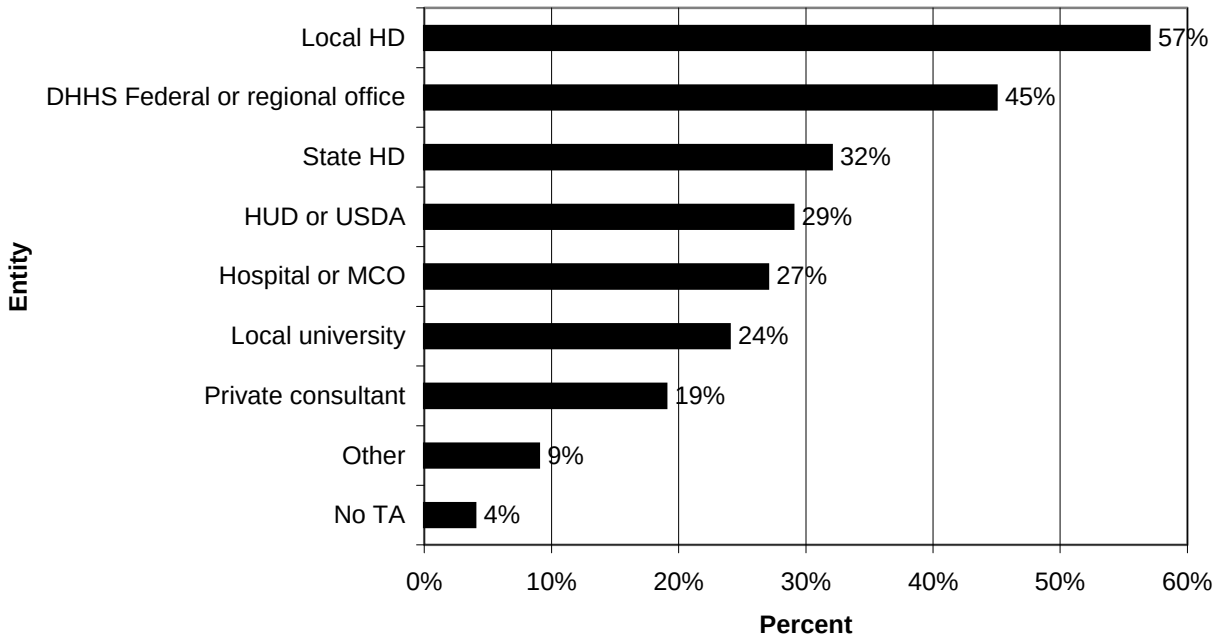
- Several EZ/EC's reported a strong capacity to engage in health planning but a lack of financial support prevents them from doing so.

Figure 16. Technical assistance EZ/ECs would use if offered (n=119) Q14 b.



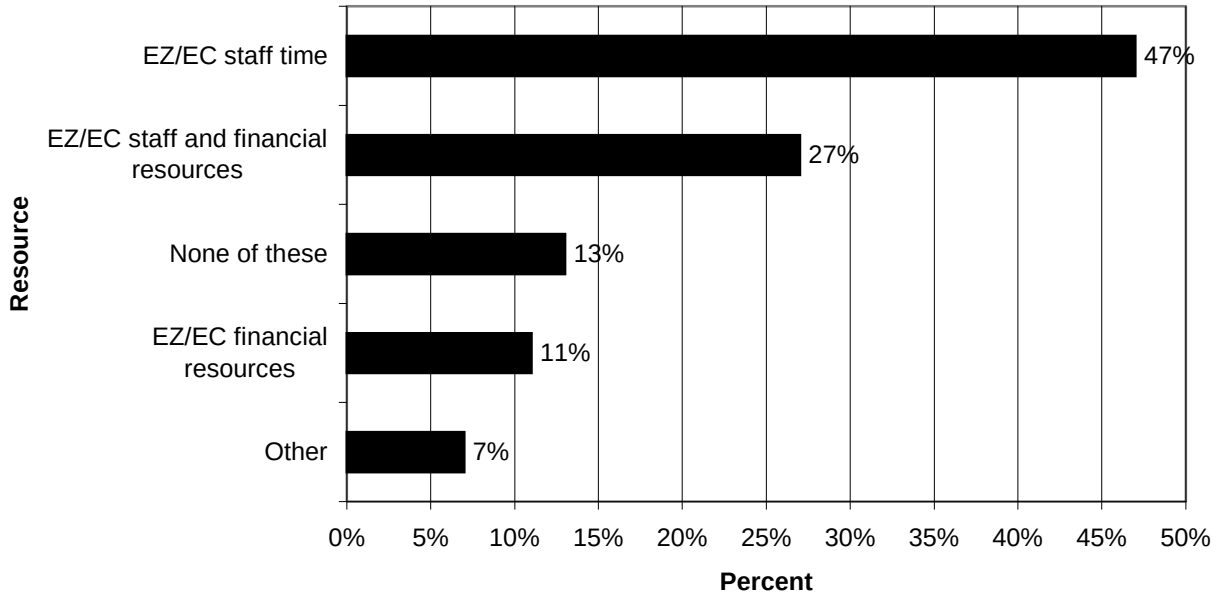
- Other areas of desired technical assistance: financial resources, performing an EZ health needs assessment using MAPP, bridging the gap between tribal and non-tribal participation, technical advice on specific health problems.

Figure 17. From whom EZ/ECs would like TA (n=119) Q15.



- Other entities included: Federally qualified health centers, local care givers, local Community Health and Safety Network, Indian Health Service regional office, coordinated TA through health partnerships, community based agencies working on health issues.

Figure 18. Resources EZ/EC could make available in next year (n=119) Q16.



- Several EZ/EC's thought they could dedicate community volunteer hours to improve health in the EZ/EC.

Cross-Tabs

Table 12. (Q1e and 14a)

Capacity Factors	Health Specific Advisory Group		
Support staff available	**Yes**	**No**	**Not Sure**
Strong capacity	10	18	0
Some capacity	11	27	1
Weak capacity	7	20	1
Participation			
Strong capacity	14	25	1
Some capacity	11	33	1
Weak capacity	3	7	0
Collaboration with mayor			
Strong capacity	21	40	1
Some capacity	4	18	1
Weak capacity	3	8	0
Community collaboration			
Strong capacity	16	31	0
Some capacity	8	30	2
Weak capacity	4	5	0
Experience guiding planning efforts			
Strong capacity	16	32	1
Some capacity	9	30	1
Weak capacity	3	3	0
Local expertise			
Strong capacity	18	28	1
Some capacity	19	28	0
Weak capacity	1	10	1
Entity accountable for health			
Strong capacity	15	16	0
Some capacity	7	26	1
Weak capacity	6	23	1
Familiar with community issues			
Strong capacity	24	33	1
Some capacity	4	28	1
Weak capacity	0	5	0

Table 13. (Q1e and 4b 3)	**Health Specific Advisory Group**		
EZ/EC has issued a written health plan	**Yes**	**No**	**Not sure**
Yes	11	7	0
No	19	63	2

Table 14. (Q 4b 3 and 8a)	**EZ/EC identified specific health issues as important**	
EZ/EC has issued a written health plan	**Yes**	**No**
Yes	19	0
No	56	37

Table 15. (Q7 and 10a)	**Included health initiatives in economic development initiatives**	
Interest in addressing health issues	**Yes**	**No**
Interested and top priority	20	20
Interested but not top priority	24	31
Not interested	0	1
No opinion	0	5

Table 16. (Q7 and 12a)	**Participation in or planned a health improvement activity in past year**	
Interest in addressing health issues	**Yes**	**No**
Interested and top priority	33	12
Interested but not top priority	23	33
Not interested	1	0
No opinion	0	5

Table 17. (Q7 and 12c 3)	**Experience organizing community health improvement planning efforts**		
Interest in addressing health issues	Much experience	Some experience	Little or no experience
Interested and top priority	14	20	3
Interested but not top priority	7	8	15
Not interested	1	0	0
No opinion	0	0	1

Table 17 – chi-square = 15.39
p-value = .0005

Table 18. (Q7 and 13 3)	**Effort EZ/EC is likely to invest in organizing community health improvement planning efforts**		
Interest in addressing health issues	Much effort	Some effort	Little or no effort
Interested and top priority	22	17	5
Interested but not top priority	10	20	23
Not interested	1	0	0
No opinion	0	1	4

Table 18 - chi-square = 16.74 / p-value = .0002

Table 19. (Q 7 and 16 3)	**Could make EZ/EC staff time and financial resources available in next year to improve health**	
Interest in addressing health issues	**Yes**	**No**
Interested and top priority	18	28
Interested but not top priority	14	43
Not interested	0	1
No opinion	0	5

Table 19 - chi-square = 4.26
p-value = .04

Table 20. (Q12c 3 and 13 3)	**Effort EZ/EC is likely to invest in organizing community health improvement planning efforts**		
Experience organizing community health improvement planning efforts	Much effort	Some effort	Little or no effort
Much experience	14	5	1
Some experience	12	16	1
Little or no experience	3	4	10

Table 20 - chi-square = 7.91
p-value = .0049

Table 21. (Q2a and 15 1	**Would like technical assistance from local health department**	
First name basis with someone at local health department	**Yes**	**No**
Yes	49	32
No	18	13

Table 22. (Q14a 5 and 14b 5)	**Desire technical assistance in guiding planning efforts with community input**	
Capacity – experience guiding planning efforts with community input	**Yes**	**No**
Strong capacity	39	11
Some capacity	36	4
Weak capacity	8	0

Table 22 - chi-square = 3.54
p-value = .0601

Table 23. (Q 14a 6 and 14b 6	**Desire technical assistance with expertise to guide the EZ/EC in health efforts**	
Capacity – local expertise available to guide the EZ/EC in health efforts	**Yes**	**No**
Strong capacity	36	11
Some capacity	36	2
Weak capacity	10	2

Table 24. (Q14a 7 and 14b 7)	**Desire technical assistance with a planning body accountable for health in the EZ/EC**	
Capacity – planning body accountable for health in the EZ/EC	**Yes**	**No**
Strong capacity	21	8
Some capacity	35	2
Weak capacity	27	3

Table 25. (Q12c 3 and 14a 5)	**Capacity for guiding planning efforts with community input**		
Experience organizing community health improvement planning efforts	Strong capacity	Some capacity	Weak capacity
Much experience	15	4	2
Some experience	13	16	1
Little or no experience	8	9	1

Table 26. (Q12c 6 and 14a 4)	**Capacity – community history of working together**		
Experience participating in health initiatives led by other groups	Strong capacity	Some capacity	Weak capacity
Much experience	21	7	1
Some experience	14	18	2
Little or no experience	2	2	1

Table 27. (Q13 3 and 14a 5)	**Capacity – experience guiding planning effort with community input**		
Effort likely to invest in organizing community health improvement planning efforts	Strong capacity	Some capacity	Weak capacity
Much effort	20	13	1
Some effort	16	18	3
Little or no effort	12	14	4

Table 28. (Q13 6 and 14a 4)	**Capacity – community history of working together**		
Effort likely to invest in participating in health initiatives led by other groups	Strong capacity	Some capacity	Weak capacity
Much effort	32	18	2
Some effort	18	21	6
Little or no effort	1	4	2

Table 29. (Q4a and 9 1, 2, 5, 11 assessed)	**Written health plan that includes the EZ/EC**		
Primary care services formally assessed	Yes	No	Not sure
Yes	17	1	3
No	38	14	30
Preventive services formally assessed			
Yes	23	2	2
No	32	13	31
Substance abuse treatment formally assessed			
Yes	18	2	7
No	36	13	27
Barriers for special populations formally assessed			
Yes	15	1	3
No	39	14	30

Table 30. (Q4a and 6b)	**Written health plan that includes the EZ/EC**		
Publications with local health statistics relevant to EZ/EC needs	Yes	No	Not sure
Yes	31	3	11
No	2	2	2
Not sure	6	0	1

Table 31. (Q4a and 11a)	**Written health plan that includes the EZ/EC**		
EZ/EC targeted special populations for health improvement efforts	Yes	No	Not sure
Yes	38	6	21
No	16	10	12

Table 32. (Q1e and 10a)	**Specific health initiatives in economic development initiatives**	
Health Specific Advisory Group	Yes	No
Yes	11	14
No	28	37
Not Sure	1	1

Table 33. (Q1e and 12a)	**Participated in or planned a health improvement activity in the past year**	
Health Specific Advisory Group	Yes	No
Yes	25	4
No	30	37
Not Sure	1	1

Table 34. (Q1e and 12c1)	**EZ/EC experience in identifying or assessing EZ/EC health needs**		
Health Specific Advisory Group	Much experience	Some experience	Little or no experience
Yes	9	15	1
No	6	24	10
Not Sure	0	1	0

Table 35. (Q1e and 12c2)	**EZ/EC experience with facilitating or mobilizing partnerships to address identified EZ/EC health issues**		
Health Specific Advisory Group	Much experience	Some experience	Little or no experience
Yes	15	10	0
No	13	18	10
Not Sure	0	1	0

Table 36. (Q1e and 12c3)	**EZ/EC experience with organizing broad community health improvement planning efforts**		
Health Specific Advisory Group	Much experience	Some experience	Little or no experience
Yes	13	11	1
No	8	16	16
Not Sure	0	1	1

Table 37. (Q1e and 12c4)	**EZ/EC experience with delivering health improvement programs for the community**		
Health Specific Advisory Group	Much experience	Some experience	Little or no experience
Yes	9	6	10
No	6	17	18
Not Sure	0	1	1

Table 38. (Q1e and 12c5)	**EZ/EC experience with setting polices within the EZ/EC that support a healthy workforce and community**		
Health Specific Advisory Group	Much experience	Some experience	Little or no experience
Yes	4	12	9
No	0	21	17
Not Sure	0	0	1

Table 39. (Q1e and 12c6)	**EZ/EC experience with participating in health initiatives led by other groups or government offices**		
Health Specific Advisory Group	Much experience	Some experience	Little or no experience
Yes	13	12	
No	12	20	6
Not Sure	1	0	0

Table 40. (Q1e and 12c7)	**EZ/EC experience with funding health programs in the EZ/EC**		
Health Specific Advisory Group	Much experience	Some experience	Little or no experience
Yes	12	7	6
No	8	21	10
Not Sure	0	1	0

Table 41. (Q1e and 12c8)	**EZ/EC experience with advocating for health policies, health programs, and services to address EZ/EC needs**		
Health Specific Advisory Group	Much experience	Some experience	Little or no experience
Yes	13	12	
No	9	15	14
Not Sure	0	1	0

Table 42. (Q1e and 12c9)	**EZ/EC experience with recruiting EZ/EC residents to participate in health efforts**		
Health Specific Advisory Group	Much experience	Some experience	Little or no experience
Yes	11	12	2
No	7	19	12
Not Sure	1	1	0

Table 43. (Q1e and 9) [formally assessed column]	**Primary care services (such as regular check-ups) have been formally assessed**	
Health Specific Advisory Group	Yes	No
Yes	9	21
No	11	53
Not Sure	0	2

Table 44. (Q1e and 9) [formally assessed column]	**Preventive services (such as pap smears, mammograms, or immunizations) have been formally assessed**	
Health Specific Advisory Group	Yes	No
Yes	12	18
No	15	48
Not Sure	0	2

Table 45. (Q1e and 9) [formally assessed column]	**Substance abuse treatment has been formally assessed**	
Health Specific Advisory Group	Yes	No
Yes	10	19
No	14	50
Not Sure	1	1

Table 46. (Q1e and 9) [formally assessed column]	**Barriers for special populations (such as such as lack of education, language barriers, or cultural competence in health services) have been formally assessed**	
Health Specific Advisory Group	Yes	No
Yes	8	21
No	10	56
Not Sure		2

Rural vs. Urban Cross-Tabs

Table 47. 12c (Rural n = 32 and Urban n = 27)

	Rural	**Urban**
Experience identifying or assessing EZ/EC health needs		
No response	3%	4%
Much experience	19%	33%
Some experience	66%	52%
Little or no experience	13%	11%
Experience facilitating or mobilizing partnerships		
No response	0%	4%
Much experience	38%	59%
Some experience	53%	22%
Little or no experience	9%	15%
Experience organizing community health improvement planning efforts		
No response	3%	0%
Much experience	34%	39%
Some experience	44%	41%
Little or no experience	19%	22%
Experience delivering health improvement programs		
No response	3%	0%
Much experience	19%	26%
Some experience	25%	52%
Little or no experience	53%	22%
Experience setting policies within the EZ/EC		
No response	3%	4%
Much experience	9%	11%
Some experience	53%	41%
Little or no experience	34%	44%
Experience participating in health initiatives led by other groups		
No response	3%	4%
Much experience	41%	56%
Some experience	56%	37%
Little or no experience	0%	4%

	Rural	Urban
Experience funding health programs in the EZ/EC		
No response	3%	4%
Much experience	31%	37%
Some experience	44%	48%
Little or no experience	22%	11%
Experience advocating for health policies, health programs and services		
No response	3%	4%
Much experience	38%	41%
Some experience	47%	37%
Little or no experience	13%	19%
Experience recruiting EZ/EC residents to participate in health efforts		
No response	3%	0%
Much experience	22%	48%
Some experience	50%	48%
Little or no experience	25%	4%

Table 48.

Capacity factors: Q14a (rural n=51, urban n=65)	Rural	Urban
Support staff available for meetings		
No response	6%	14%
Strong capacity	37%	17%
Some capacity	42%	33%
Weak capacity	16%	36%
Participation of residents and community groups		
No response	6%	14%
Strong capacity	40%	36%
Some capacity	42%	39%
Weak capacity	12%	12%
History of collaboration with the Mayor or other elected official		
No response	8%	12%
Strong capacity	65%	53%
Some capacity	22%	21%
Weak capacity	6%	12%
Community history of working together		
No response	6%	12%
Strong capacity	50%	39%
Some capacity	32%	42%
Weak capacity	12%	8%
Experience guiding planning efforts		
No response	8%	12%
Strong capacity	52%	39%
Some capacity	35%	42%
Weak capacity	6%	8%
Local expertise available to guide the EZ/EC		
No response	6%	12%
Strong capacity	46%	44%

Some capacity	36%	33%
Weak capacity	12%	12%
Planning body accountable for health in the EZ/EC		
No response	8%	12%
Strong capacity	37%	21%
Some capacity	30%	34%
Weak capacity	24%	33%
EZ/EC staff familiar with community issues		
No response	8%	12%
Strong capacity	65%	45%
Some capacity	26%	36%
Weak capacity	0%	8%

Table 49.

Area of Technical Assistance: Q14b (rural n=51, urban n=65)	**Rural**	**Urban**
Support staff		
No response	16%	15%
Yes	74%	69%
No	12%	16%
Participation of residents and community groups		
No response	16%	15%
Yes	81%	73%
No	4%	12%
Collaboration with the mayor or other elected official		
No response	18%	18%
Yes	68%	49%
No	15%	33%
Community working together		
No response	16%	19%
Yes	68%	57%
No	17%	24%
Guiding planning efforts		
No response	16%	16%
Yes	72%	69%
No	13%	15%
Availability of local expertise		
No response	16%	17%
Yes	75%	66%
No	10%	16%
Planning body accountable for health in the EZ/EC		
No response	16%	19%
Yes	79%	64%
No	6%	16%
EZ/EC staff familiarity with community issues		
No response	16%	17%
Yes	69%	58%
No	16%	24%